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**An exploration of self-reported motivation for females' use
of intimate partner violence in Scotland**

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Doctorate in Clinical Psychology

University of Edinburgh

May 2016

*Submitted in part fulfilment of the degree of Doctorate in Clinical Psychology at the
University of Edinburgh*

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ACKNOWLEDGEMENTS

Thank you to:

- My thesis supervisor Dr Ethel Quayle for being accommodating and obliging by looking at transcripts and answering many emails at any given time! Also, your enthusiasm and cheery personality throughout made a huge difference to the process. Thank you to my clinical supervisor Dr Alana Davis for the excellent clinical supervision and the endless amount of enthusiasm in driving my recruitment forward. You have been a huge influence on my training overall and I could not have done it without you! Also, big thanks to my initial clinical supervisor Dr Suzie Black for helping get the research of the ground and advice and support thereafter.
- To Willow staff for supporting the study and helping support recruitment- Terry wins the prize for her research sales pitch! A special thanks to Kirsty Pate and Colette Wormeleighton for the support- your enthusiasm for working with women in the criminal justice system is inspiring.
- The Scottish Prison Service was extremely helpful throughout the whole process from ethics and recruitment to very kindly answering never ending questions thereafter! In particular I would like to thank Jim Carnie for supporting the project from the start, Bryan Clark who supported recruitment and to Paul Davidson who was extremely helpful in sharing his knowledge on relevant policy and legislation. I would also like to thank Adam Mahoney at who also supported recruitment and was always helpful and accommodating.
- Dr Sarah Weldon for your advice on my methodology and sharing a shared interest in this area!
- My previous colleagues Dr Katharine Russell and Dr. Raj Darjee for sparking a keen interest in the area of domestic violence in the first place.

- To Stewart Stobie, Ewan Lundie and Nicola Graham-Keevan- for your knowledge of the literature and well....everything forensic!
- To DC Keith Dickson from the Domestic Abuse Investigation Unit, Police Scotland for taking the time to meet with me and advising on the work police are doing to respond to domestic violence.
- To my fellow trainees for the support through our shared experience- particular thanks to Davina and Catriona for the no ending support provided through a certain whatsapp group!
- To my good friend and forensic colleague Dr Helen Bratton for listening to my endless rants and providing a supportive caring ear throughout and reminding me of the importance of having fun.
- On a personal note, the biggest thank you goes to my amazing family for making my education possible and always believing in me. Their emotional and practical support (endless childcare) has been monumental in my achievements. I feel very lucky to have such amazing, supportive people in my life that I now look forward to having more time with! And finally, thank you to Andrew for bearing with me through this thesis journey and providing endless amounts of patience and long welcomed breaks. I promise this is my last time studying! I'm excited about the new adventures- no more "octopus" moments.

This thesis is dedicated to everyone who has been affected by intimate partner violence and family violence.

TABLE OF CONTENTS

Research Portfolio Abstract	1
JOURNAL ARTICLE 1: SYSTEMATIC REVIEW	2
Abstract.....	3
Introduction	4
Methods.....	9
Results	10
Discussion.....	32
JOURNAL ARTICLE 2: EMPIRICAL STUDY	46
Abstract.....	47
Introduction	48
Methods.....	53
Results	60
Discussion.....	74
Thesis Portfolio References	87
Appendices	99

WORD COUNT MAIN BODY OF TEXT): 23,079 (excluding research portfolio references and appendices)

LIST OF APPENDICES

1. Manuscript guidelines for Journal of Forensic Mental Health
2. Quality rating criteria
3. Manuscript guidelines for the Journal of Family Violence
4. Semi-structured interview schedule
5. NHS ethical approval
6. City of Edinburgh Council Ethical Approval
7. Scottish Prison Service Ethical Approval
8. Participant information sheet
9. Participant Consent Form
10. Data Coding Sheet
11. Reflective Journal

THESIS ABSTRACT

Background: The perpetration of intimate partner violence by women remains a controversial issue with historical focus on males as perpetrators and females as victims. The Domestic Violence, Crime and Victims Act (2004) in the United Kingdom emphasised the importance of arresting domestic violence perpetrators regardless of gender and this has resulted in significant arrests of female perpetrators of IPV. This has been paralleled by a growing interest in understanding these offenders. Central to this, is gaining an understanding of the aetiology of this population of offenders and their motivations for perpetrating IPV. Investigating this empirically may inform understanding of females' pathways into perpetrating IPV and may also inform treatment pathways and risk management of these offenders.

Design/Methodology: Aims are addressed separately in two journal articles. In journal article 1, systematic searches of bibliographic databases, in addition to hand searches of various articles was conducted to identify any association between personality psychopathology and the perpetration of IPV in females. Journal article 2 describes an empirical investigation of motivation in 8 female IPV perpetrators through semi-structured interviews. The data was transcribed and analysed using interpretative phenomenological analysis.

Results: The results of the systematic review revealed an association with personality psychopathology and female perpetration of IPV, in particular cluster B traits. In relation to motivations the results revealed the value of considering offence supportive cognitions which underpin females' motives for IPV, in addition to the context of women's lives and the dynamic of the relationship.

Conclusions: The relevance of personality psychopathology identified in journal article 1 is discussed in relation to assessment and intervention, in addition to limitations of the synthesis and clinical and empirical utility. The offence supportive cognitions identified in journal article 2 are discussed in relation to other offending behaviour groups, in addition to their clinical implications in the development of assessment and management of this population and of the development of effective interventions.

SYSTEMATIC REVIEW

Personality Psychopathology correlates in Female Intimate Partner Violence: A
Systematic Review

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Prepared in accordance with guideline for the *International Journal of Forensic
Mental Health* (see Appendix 1)

Word count: 6, 602 (excluding tables and references)

ABSTRACT

Background: personality pathology has been highlighted as relevant to male perpetration of intimate partner violence (IPV). It is unclear from the empirical evidence whether this also applies to female IPV perpetration as there are few published studies in this area. This would have implications for risk assessment, management and treatment of this group of offenders.

Aims: this review systematically evaluated the empirical evidence for an association between personality pathology and perpetration of IPV in females.

Results: the search resulted in 19 studies that met the inclusion criteria. Most were of fair methodological quality but had several limitations. Findings indicated that personality factors may be relevant to female perpetration of IPV and also female victimisation, particularly cluster B traits.

Conclusion: The review highlights the need for assessment of personality psychopathology, as well as assessing for victimisation in this group of offenders. The heterogeneity of this group of offenders should be considered in risk assessment, management and treatment. Further research is needed to explore the interacting and mediating effects of various factors on females' perpetration of IPV, and the underlying psychological processes involved.

Keywords: intimate partner violence, personality, psychopathology, women offenders, female offenders

Introduction

Definition, Prevalence and Effects of IPV

The complexity of violence in intimate relationships has been difficult to define due to there being no statutory definition of intimate partner violence (IPV) and a variety of definitions are used in research, media and societal discourses. The U.K cross-government definition of domestic violence and abuse is: ‘any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to: psychological, physical, sexual, financial or emotions’ (Home Office, 2013). However, it is questionable as to how likely it is for any family member or intimate partner to have never used a single incident of controlling or coercive behaviour. Dixon and Graham-Kevan (2011) define IPV as “any form of aggression and/or controlling behaviours used against a current or past intimate partner of any gender or relationship status” (Dixon & Graham-Kevan, 2011, p. 1145). This can include physical, sexual or psychological aggression and addresses some of the definitional challenges. It provides a clearer focus on abusive behaviours without capturing single incidents which are arguably likely to occur in the majority of relationships (Dixon & Graham-Kevan, 2011).

There have been difficulties in establishing prevalence rates due to methodological differences across studies, with some sampling occurring in non-clinical community cases of IPV and others focusing on clinical women’s shelter samples (Ehrensaft, Moffitt & Caspi, 2004). However, similar prevalence rates for male and female perpetration have consistently been found in large scale survey research using national samples and empirical meta-analyses (Archer, 2000, 2006; Dutton, 2007; Lussier, Farrington & Moffitt, 2009; Moffitt, Robins & Caspi., 2001; Straus, 2008). Statistics indicate that 1.2 million women (7%) and 800,000 (5%) men were victims of IPV in the UK in 2011/12 (Office for National Statistics; ONS, 2013). Many studies of which used a broad range of samples, have highlighted that a large percentage of IPV is bidirectional or mutual (e.g., Graham-Kevan, 2006; Katz,

Kuffel & Coblenz, 2002). The Partner Abuse State of Knowledge Project's (PASK; 2012) review of 50 studies that reported rates of bi-directional versus unidirectional violence reported that, within a large population sample, 57.9% of IPV was bidirectional.

There is considerable research investigating the impact of IPV victimisation. A systematic review with both male and female adults revealed the most significant mental health outcomes associated with IPV were depression, posttraumatic stress disorder, and anxiety (Lagdon, Armour & Stringer, 2014). Preliminary studies which have been conducted specifically on the effects of female to male violence have found that male victims can experience psychological distress, alcoholism and post-traumatic stress symptoms (Hines & Douglas, 2011; 2012) highlighting a considerable overlap between male and female victims.

Theories and Risk Factors Associated with IPV

Feminist theories suggest that gender socialisation of male dominance, power and control over women is central to IPV (Dobash & Dobash, 1979; Pence & Paymar, 1993). Consequently, much of the research has focused on investigating males as perpetrators and females as victims of IPV. However, other research has revealed a lack of empirical support for patriarchy as a sole risk factor (O'Leary, Smith, Slep & O'Leary, 2007; Stith, Smith, Penn, Ward & Tritt., 2004; Sugarman & Frankel, 1996). A wealth of research has indicated that alternative factors at different levels of an 'ecological model' may have more validity in explaining the aetiology of IPV perpetration (Dutton, 1995, 2006; Hamilton-Giachritsis & Browne, 2008; Holtzworth-Munroe, Meehan, Herron, Rehman & Stuart, 2000; Holtzworth-Munroe, Meehan, Herron, Rehman & Stuart, 2003; Stith *et al.*, 2004). In line with this, Dutton (1995, 2006) proposed a 'nested ecological model' which identifies variables that are associated with the individual, social context and broader societal system and cultural factors. It has been hypothesised that multi-factorial perspectives of IPV, which are contrary to feminist explanations, are more reliable and valid at identifying factors which predict risk of violence (Dutton, 2006; O'Leary *et al.*, 2007; Stith *et al.*, 2004). Evidence to support this multi-factorial conceptualisation of IPV has been

provided by Stith *et al.*, (2004). This study highlighted how multiple factors drawn from varying ecological levels interact with each other to predict IPV. Stith *et al.*, (2004) conducted a meta-analysis of 85 studies using Dutton's nested ecological model as a framework to assess risk factors which pertain to male perpetration and female victimisation of IPV. The findings revealed large to medium effect sizes for microsystem variables of sexual abuse experienced by the perpetrator, emotional abuse of a partner and history of partner abuse; exosystem variables of career/life stress and ontogenetic factors related to illicit drug use, attitudes condoning marital violence, anger and hostility, alcohol abuse, depression and traditional sex-role ideology. When investigating victims, Stith *et al.*, (2004) found that the microsystem characteristic of violence towards a partner is the biggest predictor of also being victimised. This was followed by ontogenetic variables of depression and fear of partner. Stith *et al.*, (2004) established that factors which are less predictive of IPV are those which are most distal from the act of violence, for example career/life stress. However, factors which are most important in understanding IPV are factors which are closely related to the context of the violence and to the individual (e.g. personality psychopathology).

An additional study which examined multiple factors as predictors for IPV was conducted by O'Leary *et al.*, (2007). Using a representative community sample of couples (N=453), they found that direct predictors for male and female IPV ranged from dominance and jealousy, marital adjustment and partner responsibility attribution. They also concluded that witnessing violence within the family, anger expression and perceived social support are all variables associated with male perpetration of IPV. In relation to females, a history of aggression as a teenager is predictive of IPV. They proposed that a surprising find to their study is that alcohol abuse is not a causal variable for IPV and therefore this is not a plausible direct or indirect predictor of IPV. As a result of their findings, the authors highlighted the relevance of exploring IPV using an integrated approach from a variety of perspectives, particularly from an ontogenetic and psychological perspective.

Variables associated with IPV

A crucial factor for IPV perpetration is psychopathology. IPV perpetrators often display depressive symptoms, conduct problems, and/or antisocial behaviour (for example, bullying), in childhood or adolescence and personality disorders in adulthood. This includes antisocial, borderline, and narcissistic personality disorders (Capaldi, Knoble, Shortt & Kim, 2012; Corvo & Johnson, 2013; Falb, McCauley, Decker, Gupta, Raj & Silverman, 2011). Similarly, research has shown that IPV perpetrators commonly present with psychological problems, such as anger, cognitive biases, hostility, distorted perceptions of the partner and children, anxiety, social and communication difficulties, deficits in impulse control and executive functioning, irritability, and other deficits, such as drug and alcohol abuse (Becerra-Garcia, 2014; Capaldi *et al.*, 2012; Corvo & Johnson, 2013; Lohman, Neppl, Senia & Schofield., 2013). Studies have, however, primarily focused on male perpetrators of IPV.

More recently, there is some indication that there may be a common pattern of personality-related psychopathology in female perpetrators of IPV (e.g. Goldenson, Geffner, Foster & Clipson, 2007), including significant elevations (i.e. suggestive of the potential for a personality disorder diagnosis) on subscales on the Millon Clinical Multiaxial Inventory III (MCMI-III; Millon, Davis & Millon, 1997) that tapped into borderline, antisocial and narcissistic traits. Accordingly, it is possible that any combination of these and other personality features (e.g. dependent and histrionic traits) may be related to female-perpetrated IPV.

Personality disorder has implications for risk assessment, treatment and management (Russell, 2016). It is relevant to risk assessment as both personality disorder in general and specific types of personality disorder have been found to be related to higher rates of reoffending, for example antisocial personality disorder (Hanson & MortonBourgon, 2004; Bonta, Law & Hanson 1998) and psychopathy (Hemphill, Hare & Wong, 1998). Ultimately, understanding personality is crucial to the development of a risk formulation. Understanding how someone functions allows

us to hypothesise what may lead someone to offend (Russell, 2016). Personality Disorder is relevant to treatment as studies have shown that those with personality disorder have a poorer response to treatment and have been found to be more likely to disengage and drop out of treatment (Gunderson, Prank, Ronningstam, Wachter, Lynch & Wolf, 1989; Kelly, Soloff, Cornelius, George, & Lis, 1992; Skodol, Buckley, & Charles, 1983). In order to benefit from treatment, treatment needs to be responsive to the patient's personality traits, i.e., the intervention needs to be tailored to the learning style, motivation, abilities and strengths of the offender (Bonta & Andrews, 2007). With regards to risk management, it is relevant because personality will affect an offender's motivation and ability to engage with a risk management plan. Without understanding personality it is possible that a risk management plan includes strategies that are counterproductive or unlikely to work.

The Current Review

To date, existing reviews have been thematic rather than systematic (e.g. Dutton, 2005; Cattaneo and Goodman, 2005) and none have focused exclusively on female perpetrators. In addition, the review by Stith *et al.*, (2004) was unable to assess the aetiology of female perpetrated IPV due to the lack of good quality studies at this time. Identifying primary risk factors that may be a predictor of IPV can help to inform treatment focus and standardise measures used in the risk assessment process and may, also be used to inform the preventive strategies. As aforementioned, the presence of personality disorder has implication for risk assessment, management and motivation for treatment. The current review aims to clarify and summarise the current body of scientific knowledge of heterosexual IPV (Capadi *et al.*, 2012) in response to calls for more rigorous research on female to male IPV. The review will critically appraise the current research base regarding the relevance of personality psychopathology in women who have perpetrated intimate partner violence, with particular focus on what is known about the nature of personality in this population and clinically relevant correlates of personality psychopathology. Moreover, it identifies gaps in the current literature and offers recommendations to improve the investigation of IPV in heterosexual relationships.

Method

A systematic review of the literature was conducted to identify studies that explored the association between personality correlates and female perpetration of IPV.

Inclusion/Exclusion Criteria

The search prioritised published primary empirical studies that used quantitative methodologies. Inclusion criteria were: 1) adult (18+ years) samples only, 2) female only or mixed gender samples, 3) use of a measure of intimate partner violence in heterosexual relationships, (4) use of standardised measures of personality and 5) published in English. Studies were excluded that used: 1) samples containing predominantly males (90% or more), 2) exclusively homosexual relationships 3) juveniles (below age 18), 4) qualitative methodology, 5) was a review or theoretical article and 6) report on personality characteristics (e.g. five factor personality taxonomies) only.

Search Strategy

Literature searches were carried out in February 2016 and informed by guidance from the Centre for Reviews and Dissemination (CRD; 2008) and Popay, Roberts, Snowden, Pettigrew, Arai *et al.*, (2006).

The following search terms were used in multiple combinations and modified to each database:

- i) (personality disorder OR personality traits OR personality profiles OR personality correlates)
- ii) (“intimate partner violence”* OR “domestic violence” OR “spouse abuse” AND
- iii) (female OR women OR gender* OR “women offenders” OR “female offenders”).

The electronic databases searched in February 2016 were: Applied Social Sciences Index and Abstracts (ASSIA), Campbell Collaboration Systematic Reviews, Cochrane Database of Systematic Reviews, EMBASE, Medline and PsychINFO. Manual searches were also conducted of review article reference lists and content pages of key journals (Journal of Family Violence; Journal of Interpersonal Violence; Aggression and Violent Behavior; Criminal Justice and Behavior). Key authors of review papers were contacted to enquire about unpublished studies.

Results

Selection of studies

In all 527 studies were identified from database searches. Duplicates were removed (n = 104). Screening of titles and abstracts for suitability according to inclusion and exclusion criteria resulted in a further 294 being excluded. The majority were excluded due to irrelevant study focus, male samples only or being a theoretical or review article only. This resulted in 129 abstracts being read, of which a further 68 were excluded. Full copies of the remaining 61 studies were retrieved and assessed for eligibility and three potentially relevant studies were identified through manual searches. A further 45 were excluded at this stage (reasons detailed in Figure 1) resulting in 19 studies included in this review. The study selection process is detailed in Figure 1.

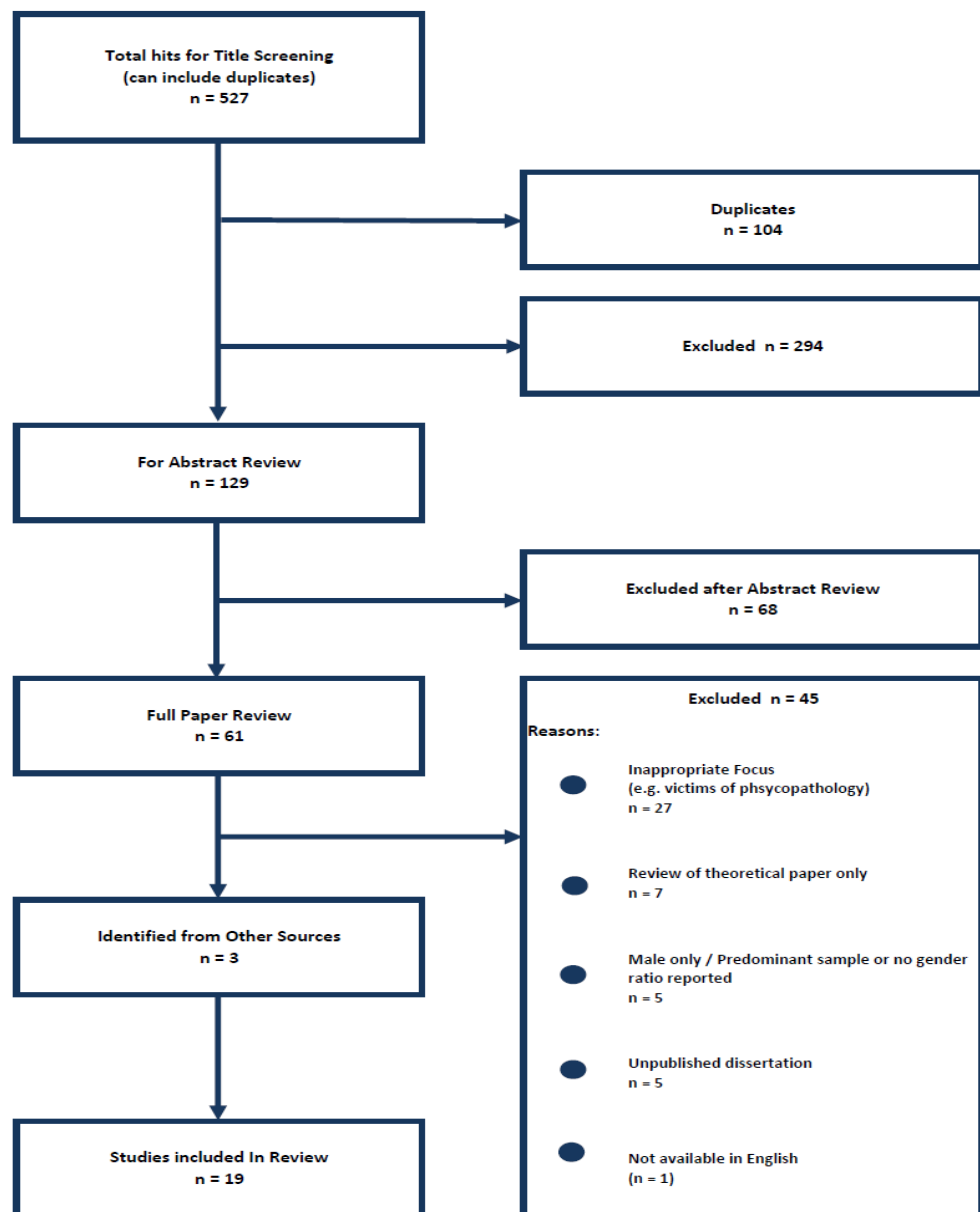


FIGURE 1: Flowchart of review study selection process

Data Extraction

The data was extracted by the main author and based on study characteristics (authors, year and geographic location, research design, type of IPV and measurement instrument), sample characteristics (size, age and ethnicity), prevalence of victimization and perpetration of intimate partner violence if reported, and IPV personality correlates findings.

Description of studies

Table 1 details characteristics and key findings of the included studies. Of the 19 studies included in the current review, 17 employed a cross sectional study design and 2 used a longitudinal design. All studies were conducted in the United States except for two from the United Kingdom, one from Canada, one from Spain and one an international multi-site study. Eleven studies reported having included predominantly Caucasian participants and 9 studies used mixed-gender samples. Although the focus of the review is on females, results for males from these studies are presented in Table 1 for comparison. The total number of female participants across studies range from 65 to 10,154. Samples were recruited from addiction treatment services (4 studies), correctional facilities (1 study), probation services (2 studies), mandated batterer treatment programs (6 studies), clinical psychiatric inpatient services (2 studies) and convenience sampling through university graduates or the community (4 studies). Four studies focused specifically on both perpetration and victimisation and its association with personality; the others explored perpetration only. Eight focused on personality correlates in addition to other variables and their association with IPV perpetration.

Due to the heterogeneity of studies, particularly in relation to definitions of IPV and measures, a meta-analytic synthesis of studies was unfeasible. Findings were instead evaluated using narrative synthesis (Popay *et al.*, 2006).

Table 1. Description of studies (results refer to women only where separated by gender)

Study	Sample characteristics	Relevant study aims	Study type and recruitment	IPV measure	PD measure	Findings
Arteago <i>et al.</i> , (2015) Spain	Perpetration only N=162 females n=43; males n=119 mean age-36.4 (SD=8.9) Prevalence: In the case of women with addiction problems 63.3% have committed IPV compared to 24.2% of men	Cross sectional; recruitment from addiction treatment programme.	To explore the specific and differential characteristics of patients presenting IPV as aggressors.	Conflict Tactics Scale (CTS2; Straus <i>et al.</i> , 1996) physical, psychological, sexual	Millon Clinical Multiaxial Inventory (MCMI-II; Millon <i>et al.</i> , 2007)	Being a woman was one of the main predictors of committing IPV. 98.4% of the cases of IPV were bidirectional MCMI-II profiles: Schizoid mean-46.8 (SD=17.7); Avoidant mean- 45.7(SD=23.3); Depressive mean=45.0 (SD=20.6); Dependent mean=45.0 (SD=22.7); Histrionic mean=47.3 (SD=18.7); Narcissistic mean=60.9 (SD=13.1); Antisocial mean=70.5 (SD=11.7); Compulsive mean=43.3 (SD 18.5); Schizotypal mean 42.7 (SD=23.6); Borderline mean 54.6 (SD=17.7); Paranoid mean=54.8 (SD=22.0)
Dykstra <i>et al.</i> , (2015) U.S.A	Perpetration and victimisation N=145 Males n=68; females n=77 Caucasian (83%); Af American (16%); other 1% Prevalence: Physical perpetration/ASPD n	Cross sectional; substance use disorder treatment seekers	To examine the association among post-traumatic stress disorder (PTSD) symptom severity, anti-social personality disorder diagnosis and IPV.	CTS (physical and psychological)	Structured Interview for DSM-IV Personality (SIDP; Pfohl <i>et al.</i> , 1995)	ASPD diagnosis significantly predicted both verbal and physical aggression; sex moderated the association between ASPD diagnosis and physical violence. ASPD diagnostic status also emerged as a significant predictor of <i>experiencing</i> verbal aggression

	<p>=37 (48%) compared to 44% for men. Perpetration/PTSD n=57 (72%) compared to 77% for men. 45% of women report both perpetrating and being victimised compared to 50% of men.</p>					PTSD symptom severity significantly predicted engaging in verbal, but not physical, aggression.
<p>Goldenson <i>et al.</i>, (2007) U.S.A</p>	<p>Perpetration only</p> <p>Female offender group (FOG) n = 33 M age = 30.9 (SD = 7.8) White (42%); African American (21%); Hispanic (15%); others (21%)</p> <p>Clinical comparison group (CCG) n = 32 M age = 32 (SD = 9.1) White (62.5%); African Amer (15.6%); Hispanic (6%); others (1%)</p> <p>Prevalence not reported</p>	<p>Cross-sectional; legal sample mandated treatment for IPV</p>	<p>To examine the attachment style, trauma symptoms, and personality organization of females mandated for treatment for IPV.</p>	<p>FOG-demographic report CCG-CTS-R & demographic report Type not reported</p>	<p>MCMI-III</p>	<p>FOG scored higher than CCG on CCG BPD, ASPD, attachment insecurity, and total trauma scores</p>
<p>Henning <i>et al.</i>,</p>	<p>Perpetration only N=2,535</p>	<p>Cross sectional;</p>	<p>To compare</p>	<p>CTS (physical</p>	<p>MCMI-II</p>	<p>Of the females in the sample 95%</p>

(2003) U.S.A	male n=2,254; females n=281 Mean age=32.5 (SD=9.3) Af American (84.2%) Prevalence not reported	convicted probationers.	characteristics of males and females arrested for domestic violence	violence only)		were elevated in one or more of the personality subscales compared to 69.8% of the males. The most commonly elevated personality subscales for both men and women were Compulsive and Narcassistic subscales. Compared to men women were more likely to evidence elevations on the histrionic and borderline subscales.
Hines (2008) International multi-site	<i>Perpetration only</i> N= 14,154 females n=10,100 males= 4,054 <i>Prevalence</i> Any physical aggression ranged from 11.6-54.8%; any severe physical aggression ranged from 2.0-25% Any psychological aggression ranged from 42.9-90.9% in USA sites for women; severe psychological aggression ranged from 7.6-60.3% Any sexual aggression ranged from 4.7-58.3%; any serious sexual aggression ranged from 0-10.5%.	67 university sites across the world To examine the association among post-traumatic stress disorder (PTD) symptom severity, anti-social personality disorder diagnosis and IPV.	To investigate whether borderline personality differentially predicted the use of partner aggression for men and women.	CTS2 (physical, psychological, sexual)	BP scale of Personal Relationships Profile (PRP; Straus <i>et al.</i> , 1999)	BP predicted all forms of IPV for both men and women

Hughes <i>et al.</i> , (2007) U.S.A	<i>Perpetration only</i> N = 80 M age = 31.5 (SD = 9.3) Caucasian 78% Prevalence not reported	Cross-sectional; legal sample-were mandated to engage in IPV intervention programming	To explore factors that might place women at risk for utilising physical aggression in their relationship.	CTS-2 (physical aggression)	BPD subscale of the Personality Diagnostic Questionnaire-4 (PDQ-4; Hyler <i>et al.</i> , 1988)	BPD features positively associated with physical aggression BPD mediated relationship between violence in childhood and physical aggression on the CTS-2
Mager <i>et al.</i> , (2014) U.S.A	<i>Perpetration only</i> N= 250 Females (n=108; 43%) M= 34.93; SD=11.7, range of age- 44 Af American (49%); Caucasian (36%); mixed (7%); Asian (2%); Hispanic (2%); native American (1%) Prevalence not reported	Baseline data from longitudinal project; history or substance misuse and/or violence recruited from substance misuse treatment agencies or community advertisement flyers in community	To explore the relationship between distinct psychopathic traits and perpetration of IPV USA in women versus men.	CTS2 (physical only)	PCL:SV (Hart <i>et al.</i> , 1995) Borderline Personality Disorder (BPD) module of Personality Disorder Interview (PDI-IV; Widiger <i>et al.</i> , 1995)	Relationships between psychopathy factors and IPV differ by gender, with psychopathy generally exacerbating IPV perpetration in men. Factor 1 partner-IPV interaction significant for women but only marginal for men indicating Factor 1 traits playing a unique role in mutual violence in women

McKeown (2014) U.K	<p><i>Perpetration and victimisation</i></p> <p>N= 92 55% charged with violent offence; 45% charged with non-violent offences 65% in relationship with a male, 35% in relationship with female</p> <p>Prevalence not reported</p>	Cross-sectional; recruited from female prison establishment	To explore the role of attachment and personality disorder in predicting female offenders levels of perpetrating and being victimised by IPV.	CTS-2 (physical and psychological)	The BPD and anti-social personality scales of the PRP	<p>Borderline and antisocial personality disorder dimensions has a significant role in explaining domestic violence perpetrated and experienced in most recent relationships of female offenders.</p> <p>In previous, relationships borderline personality pathology was associated with victimisation; whereas anti-social personality pathology as associated with perpetrating domestic violence.</p>
Newhill <i>et al.</i> , (2009) U.S.A	<p><i>Perpetration only</i></p> <p>N = 1136</p> <p>Male 57% White 69%</p> <p>Prevalence not reported</p>	Longitudinal-follow-up post-discharge every 10 weeks for one year; clinical-psychiatric patients	To examine the degree to which BPD constitutes a risk marker for future violent behaviour and to describe the characteristic of violent individuals with BPD and the nature of their violence	Items adapted from CTS, arrest records, collateral info, patient self-report (Physical only)	SIDP-R PCL-SV	<p>Individuals with BPD were more likely to commit seriously violent and aggressive acts.</p> <p>BPD remained a significant predictor after some indices of criminality and substance abuse were controlled for (but not when ASPD/psychopathy was entered)</p>

Newhill <i>et al.</i> , (2012) U.S.A	<i>Perpetration only</i> N = 1136 Male 57% White 69% Prevalence not reported	Longitudinal measures re administered post-discharge every 10 weeks for one year; clinical- psychiatric patients recruited from inpatient units	To examine the degree to which dysregulated emotions serve as an intermediate pathway between BPD and elevated risk for violence	Items adapted from CTS, arrest records, collateral info, patient self-report (physical only)	SIDP-R	BPD was a robust predictor of future violence, but no is longer a significant predictor after adjusting for effects of emotional dysregulation
Schumm <i>et al.</i> , (2011) U.S.A	<i>Perpetration only</i> N=277 M age=39.0 Caucasian (88.4%); Af American (5.8%); Hispanic or Latina (4.0%); other (1.8%) Prevalence not reported	Cross sectional; women in substance use treatment	To investigate IPV risk factors in women in substance use treatment	CTS2 The physical aggression scale from The Buss- Durkee Aggression Questionnaire (Buss and Perry, 1992) Physical and psychological	SCID-II Socialisation Scale of the California Personality Inventory (Gough, 1994)	Antisociality/ generalised violence of each partner had direct and indirect effects on IPV. Each partner's antisociality/ generalised violence was directly related to her or his physical IPV. Female antisociality/generalized violence was indirectly related to female physical IPV via female drug use and female psychological IPV. Male antisociality/ generalised violence was indirectly associated with male physical IPV via male drinking, relationship adjustment, and male psychological IPV. A reciprocal relationship was found between partners' psychological IPV but not physical IPV.

						When accounting for other individual and relational IPV predictors, male partners' physical IPV influenced women's physical IPV, but women's physical IPV did not influence their male partner's physical IPV
Ross (2011) U.S.A	Perpetration only N = 86 Female 35% M age = 30 (SD = 10.46) Caucasian 49% Prevalence not reported	Cross-sectional; legal-IPV perpetrators referred for services	To examine the personality and situational correlates of self-reported reasons for IPV among women and men court ordered to batterers intervention	CTS-2 (physical aggression only); Controlling Behaviours Scale (Graham-Kevan & Archer, 2003)	PDQ-4	BPD traits associated with domination-punishment and emotion regulation as motivation for IPV perpetration. BPD also linked to retaliation in men. Overall, in men, reasons for IPV linked mostly to personality traits (BPD and ASPD) whereas, in women, reasons for IPV linked to both personality and contextual variables
Shorey <i>et al.</i> , (2012) U.S.A	Perpetration and victimisation N=88 mean age-30.70 (SD=10.41) Non-Hispanic White (75%); Hispanic (8%); African American/Black (6.8%); other (10.2%) Prevalence Perpetration: Psychological=43.65 (SD=38.04) Physical=19.02 (SD=29.69) Sexual=4.45 (SD=9.66) Victimisation: Psychological=45.68 (SD=37.99)	Cross sectional; convenience sample of women arrested for DV and court referred to batterer intervention	To determine the relationships between IPV perpetration, IPV victimization, and Axis I and Axis II symptomatology among a sample of women arrested for domestic violence	CTS2 (physical, psychological, sexual)	The BPD subscales of the PDQ4	Psychological aggression perpetration was positively and significantly associated with symptoms of BPD and ASPD. Physical aggression and injury perpetration was positively and significantly associated with symptoms of BPD, ASPD. For victimization, psychological aggression was positively associated with symptoms of BPD, ASPD. Physical victimization was associated with increased symptoms of BPD. Sexual victimization was correlated

	Physical=24.73 (SD=41.20) Sexual=8.04 (SD=18.17)					with increased symptoms of BPD and ASPD. For Axis II probable diagnoses, women meeting the cutoff score for BPD reported more psychological, physical, and injury perpetration, as well as more psychological, sexual, and injury victimization. For women meeting the ASPD cutoff score, they reported more psychological, physical, and injury perpetration, as well as more psychological, physical, and injury victimization.
Simmons <i>et al.</i> , (2008) U.S.A	Perpetration only N=156 Females n=78; males n=78 M age=30.44 Caucasian (50%); Af Aerican (25%); Hispanic (20%); Asian and other (2.5%) Prevalence not reported	Cross sectional; referred by the courts to a domestic violence diversion program.	To compare the personality profiles of males and females arrested for domestic violence.	Arrest for domestic violence only (type of violence not reported)	MCMI-III	Compared with male offenders, women were more likely to demonstrate elevated histrionic, narcissistic, and compulsive personality traits, and less likely to demonstrate dependant personality traits. Women in this study were more likely to display MCMI-III profiles indicating the presence of personality disorders.
Spidel <i>et al.</i> , (2013) Canada	Perpetration only Females n=136 Mean age 21.8 (SD=2.0) Asian(64.4%);Caucasian (31.8%); Canadian; First Nations (2.3%); other (1.5%) Prevalence not reported	Cross sectional; non clinical (undergraduate university students) self-identified females who perpetrate IPV.	To examine the incidence of cluster B personality traits in female IPV.	CTS (physical and psychological) Multidimensional Anger Inventory (MAI)	SCID--SR	High rate of Cluster B traits in female sample who perpetrate IPV (43.4%) Borderline personality disorder not only linked with violence but correlated strongly with severe physical violence.

						<p>Women with borderline personality traits also reported more frequently being the victim of severe violence from their intimate partner.</p> <p>Women with narcissistic personality reported perpetrating significantly more minor physical violence than those who do not.</p> <p>Women with antisocial personality traits reported perpetrating more minor physical IPV and more severe IPV than those without and being victim of more severe IPV.</p> <p>72% of female perpetrators met or exceeded cut off for identifying the presence of PTSD</p>
Stuart <i>et al.</i> , (2006) U.S.A	<p><i>Perpetration and Victimisation</i> Females N = 103 M age = 31.5 (SD = 9.6) White (78%); Af Amer (8%); Hispanic (8%); others (4%)</p> <p><i>Prevalence</i> Perpetration: physical violence mean 21.0 (SD=34.1) Psychological abuse mean=47.8 (SD=37.7) Sexual aggression mean=1.1 (SD=3.3)</p>	Cross-sectional; legal sample-referred to IPV intervention program	To examine the prevalence of psychopathology among women arrested for violence and whether the experience of IPV was associated with Axis I psychopathology.	CTS-2(both scales; physical, psychological and sexual)	PDQ-4 (BPD and ASPD subscales)	Women court mandated to attend violence IPV intervention programs were 20.3 times more likely to have BPD compared to general U.S. population.

	<p>Victimisation: Physical aggression mean=30.2 (SD=51.0) Psychological abuse mean=54.1 (SD=44.3) Sexual coercion mean=9.5 (SD=25.5)</p>					
Stuart <i>et al.</i> , (2005) U.S.A	<p>Perpetration only N=409 men n=272 females n=137 Female mean age 30.5 (SD =10.0) White (79%); black (7%); Hispanic (2%); native american (2%); Asian (2%); other (4%)</p> <p>Prevalence Perpetration: Psychological aggression mean =47.41 (SD=39.34) Physical aggression mean=23.57 (SD=35.05) Victimisation: psychological aggression mean=51.20 (SD=42.30) Physical aggression mean=31.73 (SD=50.16)</p>	Cross-sectional; men and women arrested for domestic violence	To explore the variables of personality traits, drinking patterns and marital discord and the likelihood of physical aggression	GVCTS (Physical and psychological)	Antisocial Personality subscale of PDQ4	Perpetrator antisociality was related to perpetrator alcohol problems and trait anger, both of which were predictors of psychological aggression
Varley Thornton <i>et al.</i> , (2010) U.K	<p>Perpetration only N= 297 116 (39.1%) men ;181 (60.9%) women Age range 18-49 mean=23.83</p> <p>Prevalence Perpetration: mean=2.91 (SD=4.11) Victimisation: mean=1.54 (SD=2.56)</p>	Cross sectional; convenience sample from university campus	To investigate both adaptive and maladaptive personality in violent and non-violent offending behaviour	Violent and nonviolent Offending Behaviour Scale (Thornton et al., unpublished scale) Physical only	International Personality Examination-Screening Questionnaire (IPDE-SQ; Loranger <i>et al.</i> , 1997)	<p>Cluster A PD traits (paranoid, schizoid, schizotypal) were significantly more correlated with IPV and non-violent offending in males.</p> <p>Cluster B PD traits (histrionic, antisocial, narcissistic, borderline) were related to all three offence types in both men and women.</p>

						Cluster C traits (compulsive, dependent, avoidant) were not significantly related to any offence type in either sex
Weinstein <i>et al.</i> , (2012) U.S.A	<p><i>Perpetration and victimisation</i> N = 872 Female 43% Age range 55–64; mean age-59.5 (SD=11.1) White/Caucasian (71%); Black/African (26%); Hispanic/Latino (0.9%); other (1.4%)</p> <p><i>Prevalence</i> psychological aggression perpetration mean=9.8 (SD=15.0) Physical aggression perpetration mean=0.3 (SD=15.8)</p>	Cross-sectional; community	To examine the relationship between personality pathology and frequency of self-reported psychological and physical partner aggression.	CTS (psychological and physical subscales)	SIDP-R; multi-source assessment of personality pathology by participants and informants	BPD predicted aggression towards partner after controlling for gender, education, and past year alcohol dependence. Gender moderated this association; BPD symptoms more strongly related to women's partner aggression than men's

Methodological Quality of the Included Studies

Studies were rated according to quality and risk of bias. Many checklists for rating the quality of published studies are predominantly designed to evaluate research which utilises randomised controlled trials or other experimental methodology (SIGN, 2011).

The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) initiative (Von Elm, Altman, Egger, Pocock, Gøtzsche, Vandenbroucke *et al.*, 2014) proposed a checklist developed to ensure good quality reporting of observational research. Whilst the STROBE guidelines were not designed to provide a measure of study quality per se, they do provide a framework by which to evaluate published observational research. In order to assess the capacity of the included studies to contribute to the evidence base in question, relevant items from the STROBE guidelines were used to develop appropriate quality criteria. The first author also consulted a rating guide for descriptive studies on same-sex partner violence developed by Murray and Mobley (2009, pp.369-370) which is an adaptation of the evaluation criteria by Burke and Follingstad (1999); Heneghan, Hortwitz & Leventhal., (1996) and Murray and Graybeal (2007). This rating guide was utilised recently in a similar systematic review on same-sex IPV prevalence and correlates (Badenes-Ribera Frias-Navarro, Bonilla-Campos, Pons Salvador & Monterde-i-Bort., 2015). From this, 21 criteria were developed specifically to address the aims of this review. These were rated according to the grading criteria proposed by the Scottish Intercollegiate Guidelines Network (SIGN; 2011) using the following outcome ratings: 2 = well covered, 1 = adequately addressed, 0 = poorly addressed/not addressed/not reported/not applicable. Quality was evaluated across: study design, sample selection, measurement, data, and interpretation. The first author rated all papers with another psychology colleague independently rating 30% of the studies. According to Altman's (1991) guidelines, raters were in fair agreement (.460 kappa) on the overall quality of all studies. Where there were any disagreements between raters, this was discussed between raters and a consensus rating was agreed upon. The procedure for critically appraising the studies was not designed to address all comparative merits and limitations of the research in

question, but rather to provide a guide as to the relative methodological strengths of the studies specifically to contribute to answering the questions of the current review.

Quality Ratings of Review Studies

Table 2 presents quality ratings across review studies. Key methodological limitations included failures to report on prevalence of IPV perpetration and victimisation, failure to include social desirability measures, lack of sample representativeness, poor generalizability of studies, and poor or non-reported drop-out rates. Only one study included a non-clinical control group. The studies had several overall strengths including, generally reporting of key demographics of participants, and generally including a clear statement of the recollection of IPV (e.g. in the past months”), use of validated measures for IPV, clear reporting on personality correlates and use of longitudinal designs in two of the studies. The majority of studies had an adequate sample size, although none reported on power.

Table 2: Quality Ranking of Studies (*see Appendix 2 for Quality Criteria guidance*)

Study	1		2					3								4			5			TOTAL (of 44 / mean quality score)
	Study Design		Sample Selection					Measurement								Data			Interpretation			
	1.1	1.2	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	4.1	4.2	4.3	5.1	5.2	5.3	
Arteago (2015)	2	2	0	2	0	2	2	2	1	2	2	2	0	1	2	2	1	1	2	1	1	30
Dyktra (2015)	2	2	0	1	1	2	2	2	2	2	2	0	0	0	1	1	1	2	2	1	1	29
Goldenson (2007)	2	2	0	2	1	0	2	1	2	2	0	0	0	2	1	1	0	2	1	2	1	19
Henning (2003)	1	2	0	1	1	1	2	2	1	2	0	0	0	2	1	1	1	2	1	1	1	22
Hines (2008)	2	2	2	2	2	2	2	2	1	2	1	2	2	2	1	1	1	2	1	1	2	34
Hughes (2007)	2	2	0	1	1	2	2	2	2	2	2	2	0	2	1	1	1	2	1	1	1	27
Mager (2014)	2	2	1	1	1	2	2	2	0	1	2	0	0	2	1	1	1	2	1	1	1	23
McKeown (2014)	2	2	0	2	1	2	1	2	0	2	2	2	0	2	1	1	1	2	1	1	1	28
Newhill (2009)	1	2	1	1	2	2	2	1	0	1	2	0	0	2	2	1	1	2	1	1	1	26
Newhill (2012)	1	2	1	1	2	2	2	1	0	1	2	1	0	2	1	1	1	2	1	1	1	26

Ross (2011)	2	2	1	1	0	0	2	2	0	2	2	0	0	2	1	1	0	2	1	1	1	23
Schumm (2011)	2	2	0	2	1	2	2	2	0	2	2	1	0	2	1	2	1	2	1	1	1	29
Shorey (2012)	2	2	0	1	1	0	1	2	2	2	2	0	0	2	2	2	1	2	1	1	1	27
Simmons (2008)	2	2	0	1	1	0	1	0	0	2	0	0	0	2	0	1	1	2	1	0	1	17
Spidel (2013)	2	2	2	2	1	2	2	0	2	2	1	0	0	2	1	0	1	2	1	1	2	28
Stuart (2005)	2	2	0	1	1	1	1	2	2	2	2	2	0	1	2	1	1	2	2	1	1	29
Stuart (2006)	2	2	0	1	1	2	2	2	2	2	2	1	0	2	1	1	1	2	2	1	1	30
Varley Thornton (2010)	1	2	2	2	1	1	1	2	2	2	2	2	0	2	1	2	1	2	2	1	2	33
Weinstein (2012)	1	2	1	2	1	2	2	2	1	2	2	0	0	2	0	1	1	2	1	1	1	27

Prevalence of Perpetration by Females in Intimate Partner Violence

Eight studies reported on the prevalence of perpetration of IPV (Arteago, Fernandez-Montalvo & Copez-Goni., 2015; Dykstra, Schumacher, Mota & Coffey., 2015; Hines (2008); Shorey, Elmquist, Ninnermann, Brasfield, Febres, Rothman *et al.*, 2012; Stuart, Meehan, Moore, Morean, Helmuth & Follansbee, 2006; Stuart, Moore, Gordon, Ramsey & Kahler., (2005); Varley Thornton, Graham-Kevan & Archer, 2010 and Weintin, Gleason & Oltmanns., 2012). Different recollection periods were used across studies (at some point in your life, in this past year, in the past 6 months etc.) making it difficult to compare prevalence rates across studies. The most frequently evaluated form of IPV was physical violence specifically (7 Studies) and percentage prevalence rates for IPV physical perpetration ranged from 0.03 to 63%. Other studies evaluated both physical and psychological aggression (5 studies) and separated the prevalence between IPV types. The prevalence for psychological aggression ranged from 2.6 to 49.7%. A further three studies included evaluation of sexual aggression. Of the studies which separated prevalence by IPV type, the prevalence of sexual aggression ranged from 1.07 to 58.3%. Two studies did not report on what type of IPV they were measuring

Definition and measurement of IPV

The majority of studies used a validated scale (17 studies). One study used an author devised measure (Varley-Thornton *et al.*, 2010) and one study based IPV on arrest details only (Simmons, Lehmann & Cobb, 2008). The most frequently used was the Conflict Tactics Scale in order to define and measure IPV. Different versions of this scale were used (original scale, modified scale, and revised) and studies varied in whether they used all the subscales. The CTS measures 39 behaviours, each of which are divided into 5 categories: “Negotiation, “Psychological Aggression”; “Physical Assault”, “Sexual Coercion” and “Injury”. The revised CTS (CTS2) is more comprehensive in its approach in that it has 12 items to measure items to measure physical aggression, compared to 7 items in the original version. One study was not clear as to what type of IPV they were measuring (Goldenson *et al.*, 2007).

Measurement of Personality Pathology

Across studies, self-report measures were the most common assessment tools. Four studies used a structured clinical interview to assess personality criteria such as the Structured Interview for DSM-IV Personality (SIDP; Pfohl, Blum & Zimmerman., 1995). The most frequently used self-report measure was the Multiaxial Inventory (MCMI-III; Millon, 1994) which was used in 4 studies. Other measures included the Personal Relationships Profile (PRP; Straus & Mouradian., 1999) which was used in 2 studies, the Personality Diagnostic Questionnaire (PDQ4; Hyer, Rieder, Williams, Spitzer, Hender & Lyons, 1988) used in 3 studies, the Personality Disorder Interview (PDI-IV; Widiger, Mangine, Corbitt, Ellis & Thomas, 1995) used in 2 studies, the Socialisation Scale of the California Personality Inventory (SCID-II; Gough; 1994) used in 2 studies, and the International Personality Examination-Screening Questionnaire (IPDE-SQ; Loranger, Janca & Satorius, 1997) used in 1 study.

Type of personality psychopathology in women who have perpetrated intimate partner violence

There was evidence across all studies highlighting an association between personality pathology and female perpetration of IPV. A range of personality traits were identified. However, studies varied in relation to the types of personality psychopathology they explored. Some studies focused specifically on exploring an association between BPD traits and its relationship to female IPV (Hines, 2008; Hughes, Stuart, Gordon & Moore, 2007; Newhill, Eack & Mulvey, 2009; Newhill, Eack & Mulvey, 2012). Some studies focused specifically on the association between anti-social personality disorder (ASPD) traits and IPV (Dykstra *et al.*, 2015; Schumm, O'Farrell, Murphy, Murphy & Muchowski, 2011; Stuart *et al.*, 2005). Other studies explored both BPD and ASPD traits (Goldenson *et al.*, 2007; McKeown, 2014; Ross, 2011; Shorey *et al.*, 2012; Spidel, Greaves, Nicholls, Goldenson & Dutton, 2013; Stuart *et al.*, 2006; Weinstein *et al.*, 2012). Some studies explored a range of personality correlates (Areteago *et al.*, 2015; Henning, Jones & Holford., 2003; Simmons *et al.*, 2008; Varley-Thornton *et al.*, 2015). Only

one study explored the association between psychopathy and female IPV (Mager, Bresin & Verona, 2014).

Studies showed evidence of personality psychopathology which is greater than that found in the general population. Stuart *et al.*, (2006) compared women arrested for IPV and mandated into treatment for IPV with women from the general population, and found that the odds of women arrested for IPV, having BPD were 2.3 times greater than women in the general population. Similarly, there was evidence of personality psychopathology in non-clinical samples. Spidel *et al.*, (2013) examined the presence of cluster B personality traits in a non-clinical sample of self-identified females who perpetrated IPV. In their study they found that with the exception of women with histrionic traits, females who perpetrate IPV, with cluster B personality traits reported experiencing more frequent and severe anger responses than participants with no cluster B traits. Furthermore, a study by Goldenson *et al.*, (2007) compared 33 women mandated to IPV treatment to a clinical non-offending comparison group, and found that the female offending group scored higher on BPD and ASPD traits.

The four studies which focused specifically on BPD personality traits, all found a positive association between BPD and female IPV. The study by Newhill *et al.*, (2009) in a longitudinal design found that those with BPD traits, perpetrated more severe violence.

One study explored the specific role of the relationship between distinct psychopathic traits and perpetration of IPV in females versus men. This study assessed 250 men and women using the Psychopathy Checklist: Screening Version. Both the interpersonal-affective traits (Factor 1) and the impulsive-anti-social traits (Factor 2) of psychopathy were associated with higher frequency of IPV perpetration, however, the relationship between Factor 1 and IPV was stronger in men. The second goal of the study was to examine the moderating role of psychopathy traits in the relationship between partners' perpetration of IPV and participant perpetration (mutual violence) in both genders. The findings revealed that between partner and self IPV were similar at both low and high levels for Factor

1 in men, although the partner and self IPV were significantly stronger among women at low relative to high levels of Factor 1. This study highlighted that the relationship between psychopathy factors and IPV differ by gender.

Studies not only showed evidence of the relevance of personality pathology to IPV perpetration, but also to victimisation, in particular BPD traits (McKeown, 2014; Shorey *et al.*, 2012 and Spidel *et al.*, 2013). McKeown (2014) in a sample of 92 female offenders found BPD and ASPD dimensions were significantly associated with offenders perpetrating IPV and being victimised in their most recent relationships. In previous relationships, BPD scores were associated with victimisation whereas ASPD score were associated with perpetration. Conversely, Hughes *et al.*, (2007) found that BPD features were significantly associated with frequency of physical aggression towards partners, but not by partners.

Some studies investigated whether there were gender differences in associations between personality psychopathology and IPV. Two studies indicated that BPD is more linked to IPV in women compared to men (Henning *et al.*, 2003; Weinstein *et al.*, 2012). Henning *et al.*, 2003) showed that women were more likely than men to have elevations on the MCMI-III: 95% of females had elevations on one or more personality scales as compared to 70% of males. The most commonly elevated personality subscales for both men and women were the compulsive and narcissistic subscales. Compared to men, women were more likely to be elevated on histrionic and borderline subscales. Ross (2011) compared by gender, and found that for both men and women, emotional dysregulation was strongly related to both borderline traits and defensive violence. In the same study retaliatory violence was associated with BPD in men only. The study by Simmons *et al.*, (2008) also discovered gender differences; however, they found that compared with men women were more likely to demonstrate elevated histrionic, narcissistic and compulsive personality traits but less likely to demonstrate BPD traits, as evidenced in the previous studies.

Although these aforementioned studies indicate there may be some gender differences in these associations, the most methodologically robust study showed no gender differences (Hines, 2008). This study found that borderline personality

dimensions predict physical, psychological and sexual IPV for both women and men in a non-clinical sample and suggests gender symmetry (Straus, 2006). Thus, it seems from this study that for both women and men, personality features that are consistent with BPD, such as instability of self and relationships, manipulation, self-harming behaviour, fear of abandonment, anger, jealousy, impulsivity and emotional volatility, are risk factors for the perpetration of IPV. However, this study consists of a non-clinical sample. There is contrary evidence from the clinical samples to suggest gender differences (Henning *et al.*, 2003).

Moreover, studies in the current review show evidence of other variables in relation to IPV. Eight studies in the current review considered other variables in addition to personality correlates as associated with IPV and overall, there was a co-occurrence of personality psychopathology with mental health problems. The findings of Shorey *et al.*, (2012) was consistent with Henning *et al.*, (2003) and Stuart *et al.*, (2006) as they demonstrated that mental health problems were prevalent in their sample. Rates of depression (40.9%), PTSD (46.6%), GAD (44.3), panic disorder (35.2%), social phobia (36.4%), alcohol disorder (31.8%), drug disorder (23.9%), BPD (29.5%) and ASPD (39.8) were all considerably higher in this sample than the estimated prevalence rates in the general population. Similarly, Shorey *et al.*, (2014) showed numerous associations between IPV perpetration and mental health. For instance, BPD, ASPD, depressive and GAD symptoms were all associated with psychological IPV, physical IPV and injury perpetration. Moreover, Spidel *et al.*, (2013) found a substantial rate of trauma symptoms in their sample with 72% of their female sample who either met or exceeded the selected cut off for presence of PTSD. However, Stuart *et al.*, (2005) found no association between IPV perpetration and mental health in their sample of women arrested for IPV.

Discussion

The 19 review studies explored personality pathology and its association to female perpetration of IPV. In relation to prevalence of IPV across the studies, despite the definitions recognising distinct forms of IPV, studies have continued to primarily

focus on physical IPV. Consequently, there is a lack of consistent evidence on the impact of psychological, sexual and controlling behaviours.

The review shows that like their male counterparts, females who perpetrate IPV show evidence of personality psychopathology. Due to methodological limitations studies have limited comparative and generalizable utility and only tentative conclusions can be drawn from them.

There was evidence across studies to show a range of personality disorder traits; however, it is evident from the review that cluster traits in particular seem to feature prominently in females who perpetrate IPV. As only one study investigated the specific role of psychopathy traits in female IPV (Mager *et al.*, 2014), no firm conclusions can be drawn. However, as this study did highlight gender differences in that Factor 1 traits may play a unique role in mutual violence in women, this warrants further investigation. This is particularly important given the link between psychopathy and violent recidivism (Hemphill *et al.*, 1998).

BPD traits in particular were not only associated with IPV perpetration but also IPV victimisation (McKeown, 2014; Shorey *et al.*, 2012; Spidel *et al.*, 2013). Given that the study by McKeown (2014) found associations between borderline personality disorder dimensions and IPV were found in current, but not previous relationships, these findings may reflect a propensity for some female BPD offenders to follow pathways from victim to perpetrator in interpersonal relationships. On the other hand, perhaps antisocial personality disordered offenders may display more general patterns of aggression throughout their lives. This may be suggestive of different typologies of female IPV perpetrators. This warrants further exploration.

However, despite evidence which highlights an association between personality pathology and risk of perpetrating IPV in females, researchers have argued that personality disorders among female violent offenders could be misleading or methodologically biased due to difficulties associated with measurement. For example, the MCMI-III has been widely criticised for over predicting personality disorders (Choca, Stanley & Van Denburg, 1997; Hart, Dutton & Newlove., 1993). Similarly, there have been criticisms of the CTS in measuring IPV (Ehrensaft *et al.*,

2004) and it has been argued that the fact that it does not take account the context within which the IPV occurs was not addressed in CTS2 (DeKeseredy & Schwartz, 1998). It also asks about the frequency of abuse in the past 12 months, so fails to detect ongoing, systematic patterns of abuse.

In addition, some of the women in several of the studies which did not consider victimisation may be victims as well as perpetrators and consequently, the observed clinical elevations may reflect their efforts to adapt to the behaviour of their partner. For example, in the study by Henning *et al.*, (2003) it was suggested that “when you have been beaten for 12 years, you become compliant if it’s in your best interests” (p.133). This highlights the importance of considering the context of the violence.

Overall, all the studies included in the review used categorical approaches as embodied in mental disorder classification systems: the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and ICD-10, where a number of different personality disorders are described. Each disorder has a certain number of traits associated with it and if, during assessment; the patient is found to have a number of these traits then they meet criteria for diagnosis. The studies in the current review are consistent with this approach and fail to recognise that features that underlie such diagnoses and those difficulties may present in varying degrees in any community based sample. A dimensional approach to categorising maladaptive personality functioning would allow for the recognition that there is considerable variation among individuals with the same DSM/ICD diagnosis. It could be argued that personality disorders are too complex and multifaceted to be accurately described by seven to nine criteria in the DSM (Widiger, 2011; Russell, 2016).

In practice, individuals rarely fit neatly into the diagnostic categories and often meet criteria spanning different categories. When a clinician is considering personality disorder as a diagnosis they must consider the range of personality traits and the degree of severity; in line with the newly proposed ICD 11 classification model. Overall, it is important to realise that personality disorder is not one entity. Two patients with a personality disorder may require markedly different approaches and intervention to address their problematic personality traits,

not only because of the various combinations of traits that can make up a diagnosis, but also because the group of offenders with personality disorders are widely heterogeneous (Russell, 2016). Therefore, this approach as recommended by Widiger (2011) should be considered in future research

Limitations of review

This review did not include grey and unpublished literature, which may have biased the results. Furthermore, the majority of the studies were North American so an element of cultural bias is possible.

In addition, most studies (89%) were cross-sectional. The limitation of such a design is that it is impossible to determine directionality and establish if personality traits are a risk factor which was present prior to the IPV or whether they are an outcome of IPV.

It is also important to note that when critiquing the quality of studies, there are tensions about whether this capturing the quality of reporting or the quality of the research design.

Implications for research and clinical practice

One of the main implications from the findings of the review is that female IPV offenders are not a homogeneous group as highlighted by the range of personality psychopathology across studies and therefore, should be treated and managed accordingly. Personality features in particular, cluster B disorders should be considered in assessment and treatment of female IPV perpetrators. To improve understanding of the complexity of factors that may impact on female IPV, future studies should explore the presence of multiple interacting variables and their mediating effects in relation to IPV offending. This requires robust and prospective longitudinal studies that are large enough to test sophisticated models and specify predictors about the association between variables rather than rely upon correlational data.

A greater understanding of needs relevant to females may inform more gender sensitive and effective risk assessments and interventions with women. Currently, there are no gender-sensitive treatment interventions that exist specifically for female IPV perpetrators within the criminal justice system in the U.K. In Scotland, the forensic Matrix was produced to reflect specific therapies that are undertaken with forensic patients to address offending behaviour. Personality Disorder appears in the Matrix under Adult Mental Health with reference to the treatment for BPD. However, within the forensic matrix it is acknowledged that many offenders have personality disorder and that, despite the fact that it is rarely the main presenting disorder; personality difficulties should always be assessed. It also highlights the importance of personality disorder in risk assessment, treatment and management. As this review highlights an association between several personality disorder traits and female perpetrated IPV, in line with recommendations set out by the Matrix, it will be important that personality pathology is assessed in this population.

According to Russell (2016) in recent years there has been convergence in the literature, where there seems to be increasing agreement that all structured psychological therapies produce improvement in Borderline Personality Disorder (Bateman, 2012; Livesley, 2005). Formulation is the key process through which key areas of need and the relevant psychological techniques to address them can be identified. Formulation will be particularly helpful given the evidence to suggest that there may be different typologies of female IPV perpetrators (McKeown, 2014). Similarly, given that Cluster B personality psychopathology, in particular appears to have relevance to female IPV, intervention should consider emotion regulation and impulsivity.

Future Research Directions

Future studies should use agreed definitions of partner violence and forms of violence (e.g. Centres for Disease Control and Prevention, 2010). The definition proposed by Dixon and Graham-Kevan (2011) may be particularly helpful given that it provides a clearer focus on abusive behaviours without capturing single incidents which are arguably likely to occur in the majority of relationships (Graham-Kevan,

2011). Studies should also report on agreed recollection periods and consider the role of both partners. This would facilitate the integration of the results in later meta-analytic studies and the comparison of different studies.

The association between personality traits and risk of intimate partner victimisation for both men and women warrants further exploration. Although, this was not considered in the scope of the review, studies should be designed to capture the dynamic nature of relationships over time and consider the role of the couple. A further criticism of measurement of IPV by the CTS is that it does not corroborate participants' reports of violence. Further research should incorporate statistical modelling which enables analysis of interdependent dyadic data. This would allow for partners contributions and possible dyadic influences to be more clearly distinguished. A recent study Maneta, Cohen, Schulz & Waldinger (2013) explored the link between borderline personality organisation (BPO) and IPV specifically in a dyadic model that accounts for each partner's influence on each other. The authors propose that the fact that more BPD pathology in both men and women is linked with increased victimisation may indicate that those higher in borderline traits are more likely to choose partners who are prone to violence. This is a question that warrants further exploration.

It would be beneficial to explore various potential mechanism factors to examine whether they interplay in important ways to promote IPV among individuals with personality pathology (e.g. attachment, substance misuse, impulsivity etc.). Jackson, Sippel, Mota, Whalen & Schumacher (2015) calls for the development and examination of more complex models detailing the developmental and static risk factors for BPD related IPV.

Although this was not the scope of the current review, the studies have highlighted the importance of exploring the impact of mental health problems on IPV perpetration and victimisation experiences of women (Shorey *et al.*, 2014; Stuart *et al.*, 2006). Additional research is needed to replicate these findings, particularly using longitudinal designs to determine whether mental health problems predict or are a consequence of IPV perpetration among women arrested for domestic violence.

Furthermore, it would also be advisable to use multiple methods for evaluating IPV, given that it is a complex phenomenon (Follingstad & Rogers, 2013), and control for social desirability problems associated with these types of behaviours (Follingstad & Rogers, 2013; Frankland & Brown, 2013). Similarly, as the majority of the studies are conducted within the USA, it is necessary to investigate the existence of this phenomenon in other societies and cultures.

Conclusions

The results of the review suggest that personality psychopathology is of increasing relevance and importance in understanding both female perpetration and victimisation of IPV. Due to methodological limitations of studies, only tentative conclusions can be drawn. However, the role of PD in women's IPV represents an important emerging research area. It is imperative not to simply examine and identify factors that may be relevant to female perpetration of IPV- and how these may or may not differ from those relevant to men- but to explore how these factors may interact in complex ways to increase the risk of IPV. It is also important to understand how different factors may function and interact to support women's desistance from IPV. Considering contextual variables and motives for IPV will also be helpful.

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JOURNAL ARTICLE- EMPIRICAL STUDY

An exploration of self-reported motivations for females' use of intimate partner violence in Scotland

Prepared in accordance with guidelines for *the Journal of Family Violence* (see Appendix 3).

Word count: 10, 735(excluding reference)

ABSTRACT

Background: there is a lack of consensus in the literature regarding reasons for female perpetration of IPV. Different theories have been proposed to make sense of this phenomenon, however, this has not adequately influenced how this type of offending is understood in relation to risk assessment, management and treatment.

Aims: to explore women's self-reported motivations for using IPV towards a male partner and to consider the role of cognition that may support this type of offending.

Method: Semi-structured interviews were conducted with eight females who had been charged or convicted of IPV. The data was transcribed and analysed using Interpretative Phenomenological Analysis.

Results: The main themes which emerged from the data were "It was him or me"; "The world is a dangerous place"; "My life is out of control"; "People let you down" and "It's us as a couple". These findings are discussed in relation to other offending groups.

Practical implications: Participants accounts highlight the utility of conceptualising IPV in terms of the relevance of cognition which underpins this behaviour. Suggestions are made in how these findings can be used to inform assessment, management and intervention. With this population trauma informed services and structured clinical care approaches may be helpful, in addition to, incorporating the identified cognitions into psychological formulation and treatment targets.

Key words: women offenders, intimate partner violence, motivations, cognition

Introduction

Intimate partner violence (IPV), was initially brought to public attention by feminist activists in the 1960s and 70s and has since remained a pervasive problem in the U.K. While it has been criticised as generally poorly defined (Bowen, 2011), many terms have been used to attempt to capture the issue of violence occurring within intimate relationships and this has sparked some debate regarding the efficacy of such terms in capturing the true nature of the problem. For example, terms such as spousal abuse, domestic violence, wife beating, battering and partner abuse interchangeably have been used within research, the media and societal discourse. Statistics by Scottish Government (2015) show that in 2013-14 there were 58,439 incidents of domestic abuse compared to 59,882 in 2014-15. They also show a rise in the percentage of male victims of domestic abuse – up from 12% in 2005-06 to 20% in 2014-15. However, the perpetration of female IPV has remained a controversial issue.

Theoretical frameworks give professionals insight into the nature of IPV and infer the course of action that should be adopted to eliminate it. The variations in the terminology and definitions of partner violence stem from the different theoretical approaches used to understand this phenomenon. Multiple theoretical approaches have led to not only differences in definitions, but also in research methodology and resultant findings. Two main perspectives that dominate research of intimate partner violence are the Gendered (also known as Feminist) and the Gender-Inclusive perspectives (Dixon & Graham-Kevan, 2011).

One of these theoretical frameworks, the feminist perspective, places the role of patriarchal attitudes as a central risk factor for IPV (Respect, 2008). The feminist perspective places IPV within a socio-cultural context based on the notion that IPV is “inextricably linked to attempts to dominate and control women” (Dobash, Dobash, Wilson & Daly., 1992, p.71) and is overwhelmingly perpetrated by males as a result of this (Dobash & Dobash, 2004). The feminist perspective has dominated the way in which public policy, service provision and assessment and intervention have been framed. Support from this perspective can be seen in a study by Miller and Melloy

(2006) which found that women on probation for IPV and mandated to court-ordered treatment were more likely to employ IPV in self-defence or as a reactive/expressive means of responding to long term/prior abuse. Similarly, Swan *et al.*, (2008) summarised literature pertaining to motivations underling women's IPV and concluded that women were more likely to be motivated by self-defence and fear. Given that women who fight back are more likely to be injured during IPV incidents (Swan *et al.*, 2008) they propose that victimisation is a critical topic to address. However, there have been criticisms about regarding the methodological focus of research oriented from this theoretical framework. Researchers have typically focused on studying female victims residing within shelters, rape crisis centres and hospitals or with men who had been trialled or convicted of such offenses (Dobash & Dobash, 1998). Due to these theoretical underpinnings there has been little study of female violence or male victimisation. Therefore, the methodological focus of such research is designed to elicit information from female victims only. Criticisms of such selected is that they are likely to give very specific results that are only generalisable to women fleeing a violent relationship. Such research has also been criticised when results have been generalised to the wider population (Straus, 1999a), for example, large scale surveys, such as the National Violence against Women Survey (NVAWS) and Statistics Canada's General Social Survey (GSS), have focused only on male violence against women. Organisations such as RESPECT, who are responsible for setting the national accreditation guidelines for perpetrator intervention programmes in the UK, suggest claims such as IPV is a gendered issue and women are typically only violent in self-defence (RESPECT, 2004). However, findings are typically based on research with selected samples and do not consider other forms of IPV that occur between couples in the general population

In contrast the gender inclusive perspective of IPV which considers a broader interaction of factors has been well documented from empirical evidence, which has questioned the efficacy of socio-cultural associations to IPV (Bell & Naugle, 2008; Dixon & Graham-Kevan, 2011; Dutton & Corvo, 2006; Hamel, 2007, 2009; Straus, 2008; Dixon & Graham-Kevan, 2011; Dutton & Corvo, 2006; Straus, 2011). Large scale survey research with national samples and empirical meta-analyses have

consistently found similar prevalence rates for male and female perpetration (Archer, 2000, 2006; Dutton, 2007; Lussier *et al.*, 2009; Moffitt *et al.*, 2001; Straus, 2008). Partner violence has also been identified in lesbian relationships (McClellan *et al.*, 2002) and females have reported using violence against their non-violent partners (Straus, 1993). IPV offenders are a heterogeneous population and gender inclusive approaches consider perpetration to be a result of a complex interplay of biological, psychological, social and contextual factors (Dutton & Corvo, 2006; Straus, 2008). This is supported by research relating to typologies of IPV offenders (Holtzworth-Munroe, 2000; Johnson, 2006). The empirical research has convincingly demonstrated the existence of different categories of IPV perpetration involving situational couple violence, controlling behaviours, self-defence behaviours and extreme responses to separation (Johnson, 1995, 2008). This evidence contradicts the feminist theoretical framework which depicts women's IPV as a product of reactivity and self-defence. This has led to investigating IPV from a gender-inclusive perspective.

A gender-inclusive approach to the study of intimate partner aggression, investigates perpetration and victimisation of both men and women in intimate relationships. This perspective assumes both members of a couple can be either victims and/or perpetrators. Studies conducted from this theoretical framework involve surveys of large community samples, which are often nationally representative, and university student samples, where measures of aggression are presented in a gender neutral context. Commonly, both men and women are asked to report on their victimisation/perpetration by completing the Conflict Tactics Scales (CTS; Straus, 1979). The CTS is a self-report tool which asks respondents to report on the use on a number of behaviours used to settle disagreements: between partners; physical assault, psychological aggression; and negotiation; and scales to measure injury and sexual coercion of and by a partner. This has resulted in large scale data collections which have revealed symmetry in the use of IPV by men and women against their partners. However, there remain to be difficulties in establishing motives for IPV because the CTS does not assess motivation, meaning, or context of violence incidents (Ehrensaft *et al.*, 2004).

In order to gather a better understanding of this controversial topic, researchers, treatment providers and other professionals have begun to critically examine theoretical research and practice perspectives; considering the context of the violence rather than relying on inferences. This has involved asking men and women why they used IPV from their own perspectives. Caldwell *et al.*, (2009) interviewed 412 women charged with IPV and discovered a number of motivational factors (e.g. self-defence, an inability to manage the expression of negative emotions, the desire to control, jealousy and 'tough guise'). Similarly, a systematic review of 23 studies that reported empirical data relating to women's motivations for IPV (Bair-Meritt *et al.*, (2010) was carried out which revealed multiple concurrent motivations for this phenomenon. This has begun to reveal the complexity of IPV and that it may be a result of multiple motivations, rather than a singular or discrete reason. It also revealed some difficulties in interpreting motivations through questionnaires. Caution was suggested in interpreting the motivation of "coercive control". It was suggested that this could be miscoded in qualitative studies due to ambiguity about the function of the behaviour, for example, a woman using IPV to force her partner out the house; although trying to control his behaviour her underlying reason may be concern for personal safety.

Although this more recent work of investigating motivation from the perspective of the offender offers an explanation as to why IPV occurs by considering the context, it does not adequately account for maladaptive beliefs and distorted thinking, which has been linked to offending behaviour in empirical research (Ward, 2000). Until recently treatment approaches such as the Duluth model (Pence & Paymer, 1993) offered a conceptualisation of IPA within feminist theory based largely on data from female victims of IPV. As with offending behaviour programmes its theoretical perspective was related to societal perspectives of male entitlement and offered no explanation as to how these views came to be held in an IPV offender.

Recently exploration of cognition in other types of offender groups has provided evidence that violent offenders typically hold similar sets of core beliefs about

themselves, others, the world and their violence that aid them in excusing their violent behaviour. Specific schemas have been recognised in sexual abusers which have, in turn been translated into treatment targets (Beech *et al.*, 2012; Fisher & Beech, 2007). Researchers have developed theories about the organization of offense supportive cognitions and their mental representation, within the theoretical framework of implicit theories (ITs), a concept similar to a schema (Ward, 2000; Ward & Keenan, 1999). ITs are “core beliefs comprising coherent, interlocking ideas and concepts that people hold about themselves, others, and the social world” (Ward, 2000). They can affect thinking, actions and the way in which behaviour of the self and others is perceived. These ITs are a product of life experience which operate like scientific theories; people utilise them to make sense of, explain, and predict their social world and interpersonal phenomena. ITs have been proposed as important in the area of violence and aggression as ITs can bias the way people interpret the world and interpersonal phenomena. This can result in the development of individual cognitive distortions; a term that refers to maladaptive beliefs and attitudes and problematic thinking styles such as excusing, blaming and rationalising. Abel *et al.*, (1984) suggested that cognitive distortions can explain how maladaptive sexual arousal develops in males as a defence mechanism which helps allow the child sexual abuser to be more at ease with their behaviour (Thakker *et al.*, 2007). In this way, implicit theories may play a maintenance role in offending behaviour. A study by Dempsey and Day (2011) provided further empirical support from Gilchrist’s conception of implicit theories with male IPV offenders. They identified three main cognitions of “threat”, retreat and “perfect world” which suggest that like other violent male offenders, IPV male offenders are ambivalent about their place in the world and have difficulties coping with its expectations, relationships and social interactions. Weldon (2016) conducted a more recent study and identified similar implicit theories in male domestically violent sexual offenders. Identifying these underlying cognitions has important implications for risk assessment because these beliefs support, facilitate or legitimise offending and are therefore considered to be key risk factors. An important part of intervention with these offenders would be identifying such cognitive distortions and their related theories, bringing them into conscious awareness and working towards changing or modifying these cognitions

that facilitate offending. It may be that women IPV perpetrators hold beliefs about themselves, others and the world that underpin their motives for their IPV offending.

It is evident that there is controversy about the aetiology of female perpetrated IPV and there is a lack of consensus regarding women's motivations for IPV. Existing theoretical models tend to depict women's reasons for using IPV as discrete and singular; the reality is likely to be more complex, with women having multiple concurrent motivations. Furthermore, the emerging evidence challenging the conceptualisation of female IPV as self-defensive has not yet been applied to treatment. This research is approached with the intention of addressing the aforementioned challenges by exploring cognition in female offenders of IPV through their own narratives, in order to inform assessment, management and treatment approaches.

Aims

The current research study aims to explore female IPV from the perspective of the perpetrators, by discussing their self-reported motivations for committing these acts and considering the role of underlying cognitions. Therefore, interpretative phenomenological analysis (IPA) was utilised to explore the participant's lived experience (Smith, 2004). Identification of cognitions which may underpin motivations specific to female perpetrators of IPV would have implications for empirical research, clinical intervention and risk assessment/management.

Method

Participants

Participants were recruited from a community criminal justice centre in Scotland (a service which addresses the social, health and welfare needs of women in the criminal justice system), local criminal justice teams and the Scottish Prison Service (SPS). Inclusion criteria were females involved in the criminal justice system with a charge or conviction related to intimate partner violence towards a male partner (past or present), aged 18 years or older, with English language proficiency.

Recruitment was challenged by the nature of the population, which has high levels of engagement difficulties, caused by instability, chaotic lifestyles, substance misuse difficulties, and difficulties with trust). Several recruited participants failed to attend for interview at least once and four became too unstable to participate post recruitment. Eight women (N = 8) participated in the study; 4 from SPS and 4 from the criminal justice centre (community). No participants were recruited from the local criminal justice authority teams. Findings by Guest *et al.*, (2006) suggest this sample size was adequate to achieve theoretical sufficiency. This is also consistent with previous empirical studies with offender populations (e.g. Blagden *et al.*, 2011; Weldon & Gilchrist, 2012).

Procedure

Community

Within the criminal justice centre eligible participants were identified by their keyworkers who provided them with a participant information sheet (PIS; Appendix 9). They were given at least 24 hours to decide if they wanted to participate. Interviews were arranged via keyworkers and all interviews were conducted by the first author either before or after keyworking sessions at the centre. Prior to interview participants completed their consent form (Appendix 9), and a Data Coding Sheet which gathered basic demographics of the participants (Appendix 10). Participants with literacy difficulties were assisted in completing these by the first author.

Prison

Three strategies were used for recruitment. A Strategy Analyst, employed by the Scottish Prison Service, was asked to conduct a search for potential recruits across three prison sites by the SPS ethics board as part of his role. A statistical report using a desktop intelligence package identified all participants who met the inclusion criteria across the three prison sites holding females in Scotland. Those identified as having a Domestic Violence Aggravation Code flagged on their profile were then sent a letter inviting them to participate in the study. At two of the prison establishments, the researcher also had the support of a mental health professional who had knowledge of potentially eligible participants due to delivering offending

behaviour programs. Within one prison establishment, a Clinical Psychologist supporting the study was able to provide information to participants as a result of her knowledge of the study. In one other prison site, a Forensic Psychologist had knowledge of some women who were eligible due to their participation in offending behaviour programs. He was also able to provide information about the study.

In addition, the researcher also displayed a poster about the research study within one prison establishment. Women interested in hearing more about the study were asked to put their name in a confidential box. The researcher or the clinical psychologist supporting the study then arranged a visit with the women to tell them more about the study, and to provide them with a PIS. They were then asked to sign a consent form if they were eligible and still wished to take part. Following this, the researcher then arranged a date to return for interview.

Interview guide.

A semi-structured interview (*Appendix 4*) was designed to explore participants' experiences of perpetration of intimate partner violence. The interview guide followed the recommendations of Smith *et al.*, (2009) and were reviewed by the co-authors. Open-ended questions and additional prompts were used as recommended by Smith *et al.*, (2009) as highlighted in Box 1. The interview began and ended with more neutral questions about the participants' relationships to allow for rapport building and sensitive interview closure. At interview, each participant was offered the opportunity for the researcher to provide a summary of the main findings.

Box 1: Example of questions and possible prompt included in the interview guide

Topic area: Reflection on motivations

Question: **“Looking back what sense have you made of what happened?”**

Possible prompts:

Why do you think it happened?

Were there triggers/specific times it was more likely to happen?

All interviews in the prison were conducted within an interview room. Participants were interviewed once and interviews ranged from 25 to 60 minutes. They were recorded using an encrypted digital voice recorder and transcribed verbatim by the first author.

Demographics

The offence history and relevant demographic information for each of the participants are outlined in Table 1.

Table 1 Demographic data of participants

No.	Age Range	Relationship Status	Prison/Community	IPV History	Previous Convictions	Children	Diagnoses
1	31-35	Single	Community	Breach of peace x2	1 Dishonesty; 3x Breach of Peace	2	Borderline Personality Disorder (BPD)
2	36-40	Single	Community	Assault to severe injury	Breach of peace; theft	1	Bipolar affective disorder; BPD
3	26-30	Single	Community	Assault to Injury & Permanent Disfigurement	2 x racially aggravated harassment	3	
4	36-40	Single	Community	Assault	Misuse of drugs Act	2	
5	51-55	Single	Prison	Murder	4 drug offences	2	
6	26-30	Single	Prison	Assault	Murder (stranger)	0	BPD
7	31-35	In a relationship	Prison	Assault to severe injury	35 (mainly drug offences)	0	BPD
8	41-45	Single	Prison	Attempted murder	Murder (stranger)	5	

Ethical considerations

The study was approved by the National Health Service (NHS) East of Scotland Research Ethics Committee and the local Research and Development Office (Appendix 5), the Scottish Prison Service (Appendix 7) and the Department of Health and Social Care (Appendix 6). Participation was voluntary and confidentiality was maintained within standard clinical guidelines, with interview data anonymised and stored according to NHS policies and procedures. The first author was transparent about her dual role as researcher and practitioner in the female offender service, although none of the participants were or had been seen for psychological therapy by the first author.

Due to the sensitive nature of the research there was potential that participants would be destabilised by talking about these past experiences. In particular, their

experiences may have been linked with violence towards themselves as well as the violence they perpetrated, children observing violence or being taken into care as a result of charges/convictions. In the community setting keyworkers within the criminal justice service were involved and the researcher provided the participants an option of debriefing with the researcher and their keyworker after the interview if they felt this was needed. In the prison, the same process was followed with the Personal Officer (PO) who held a role similar to a keyworker. Thus, the researcher offered to inform the PO of their participation should they have become distressed and needed support post interview. No participants in the current study required this. An advice sheet was provided to each participant with telephone numbers of internal and external support lines should the interview evoke thoughts or feelings which they would benefit from talking through with a professional.

Design

The primary goal of Interpretative Phenomenological Analysis (IPA) is to investigate how individuals make sense of their experiences. It is assumed that people are ‘self-interpreting beings’ (Taylor, 1985) which means that they are actively engaged in interpreting the events, objects and people in their lives. Therefore, the goal of IPA is to study how people make meaning from their lived experience. The central concern is the subjective experience of the individual. This is in contrast to grounded theory which seeks to identify and explicate contextualised social processes which account for phenomena rather than seeking to capture the nature of the phenomena by understanding individual experience (Eatough *et al.*, 2008).

IPA has been utilised in similar research exploring aggression and anger in women (Eatough *et al.*, 2008) and has also been widely used with other forensic populations (Blagden *et al.*, 2011); Weldon & Gilchrist, 2012). It has also been proposed as particularly useful in this population as it assumes a link between what the participants say and underlying schemas (Brown & Beail, 2009). Thus, through a process of interpretation, cognitions can be accessed as well as a description of behaviour (Brown & Beail, 2009).

In accordance with IPA methodology (Smith *et al.*, 2009) interviews were semi-structured and non-prescriptive to allow the participant to reveal their own cognitions, beliefs and feelings. These enabled participants to have ownership of the direction of the conversation while the researcher implemented non-directive triggers to aid exploration of relevant topics as they emerged (Brown & Beail, 2009). Consequently, cognitions would emerge through the women's narratives.

Data Analysis

Data were analysed in accordance with IPA methodology in order to make sense of and explore the participant's lived experience from their perspective (Smith & Osborn, 2003; Smith *et al.*, 2009). Transcripts were first read in detail several times in order to commence a sustained engagement with the text. Subsequent to detailed reading of the text, notes were made by the researcher in the left hand margin to identify prominent points; associations and contradictions. Thereafter, these notes were used to establish potential emergent themes which are documented in the right hand margin. These themes were recorded in the form of phrases and attempted to capture the essence of what was being discussed and what sense the participant was making of their world (Smith & Osborn, 2003). IPA recognises the importance of the researcher in the analytic process which is described by Smith (2004) as a dialectical interpretative relationship between the researcher and the text. Consequently, the construct of the participant's world is not readily available but rather accessed through sustained engagement and interpretation of the text (Smith & Osborn, 2003). Consequently, analysis is an interactive process open to influence from the researcher's beliefs and cognitions, and these must be made explicit, as far as possible, to put the analysis into context. The researcher maintained a reflective journal throughout the research process in order to be as transparent as possible (Appendix 11). Participants' phenomenologies begin to be interpreted at this stage through a dialogue between the text and theoretical constructs underpinning these. The researcher looked across transcripts for emerging themes which could be grouped together. These were listed separately and thereafter reviewed in relation to each other to through a process of abstraction, subsumption, and polarisation to

produce main overarching themes and then subordinate theme which branched from these.

Extracts from the interviews are used to illustrate the analysis and pseudonyms were used throughout, including when names of victims and/or family members were mentioned, to ensure anonymity was maintained.

Quality Assurance

In accordance with Smith (2011) a theme was evidenced if it was present in extracts from at least three of the participants. As a means of quality assurance Smith *et al.*, (2009) suggests an audit of the process. Qualitative transparency can be more difficult to achieve than quantitative since its interpretation is within the parameters of the researchers' knowledge and empirical context. As an audit check a second researcher looked at sections of 3 coded transcripts to examine the rigour, transparency and coherence of the analysis.

Results

Five main themes were identified from the data in relation to motivations for female perpetration of IPV: "The world is a dangerous place"; "It was him or me"; "My life is out of control"; "People are not there for me"; and "It's us as a couple".

Each of these themes and subthemes is discussed along with extracts from participants to illustrate the derived theme. Within extracts "P" refers to participant and "I" refers to "interviewer" to ensure anonymity.

Theme 1: The world is a dangerous place. This reflected participants conveying beliefs about the world being a dangerous and hostile place in which to live. This sense of danger and constant threat was pervasive across diverse relationships and settings. All participants portrayed a sense of violence having a significant influence on their upbringing either from witnessing violence in the family home or within their peer group. Several participants discussed male figures in their lives as having been abusive in their childhood.

P: *Aye a moved myself out the family home when I was 14 eh. Put myself into care cause meant he [stepfather] wouldn't touch my stepbrothers and sisters eh. It was me who used to get it cause I was the oldest and I wasnae his daughter and I had bladder problems so I used to wet the bed and stuff so he used to rub my face in it, made me stand and wash the sheets and then my mum would go mad. He would attack my mum and then I used to try and attack him. – Jackie*

Jackie's extract shows that she was socialised to violence from a young age by witnessing her stepfather's violence towards her mother. He was also emotionally abusive towards her, which may have led her to develop cognitions around people being dangerous and a view of needing to protect the self and others. This may have contributed to beliefs that "violence is normal" and the only way to keep yourself and others safe in her view of an unsafe world. Consequently, it may be that witnessing interparental violence has led to a sense of acceptability of violence in intimate relationships specifically.

Similarly, another participant spoke about violence being a normal part of growing up in her culture.

P: *I'm sorry like I grew up in the hood and you don't sit down and have a reasonable discussion with nobody you know what I mean, It's like you are gonna get thumped and that's it basically. You look at someone the wrong way, you gonna get your face ripped off you know what I mean so... -Kate*

This participant's narrative conveys a sense of developing beliefs around the world being a dangerous and hostile place where even a look from someone "you look at someone the wrong way" can be a threat or sign that something violent may be about to happen. The statement "you don't sit down and have a reasonable discussion with nobody" suggests that this participant may have developed a sense that just talking

with someone is not enough where she is from, resulting in beliefs about violence being the only means of dealing with conflicts or problems.

Another participant spoke about her index offence (murder of a stranger) for which she is currently serving her custodial sentence. In her account of the offence she talks about being outside a local takeaway and going back inside to find her brother fighting with a man. She then describes immediately jumping into the fight, despite not knowing the circumstances. She spoke about how in her childhood they were taught to stand up for each other and that violence was the way to do this.

***P:** Well my brother was stabbed before and I think...you know [researchers name] we were all brought up to stick by each other you know...see if I was out there fighting and it was just...that was just the way it was done back in the day...you know...but you don't kinda sit about and think of the consequences and whatever...it was just...fucking attack really. – Carol*

Carol's narrative highlights that again she was socialised to violence at an early age. She also described other traumatic events in her childhood, including sexual abuse and her brother being stabbed, which may have led her to develop cognitions about the world being a dangerous place. It also gives a sense of how violence may have had value to her as it kept closeness between her and siblings and it was how they showed they cared about each other. The fact that her brother had been stabbed before, highlights that she has experienced a real sense of danger in her life where her brother's life has been at threat. This may have led to a heightened sense of danger that something equally bad might happen. She instinctively jumps in to protect her brother and show that she cared. There is a sense for these women that at times they lived in a 'kill or be killed' world.

Theme 2: It was him or me. This is related to occasions where participants described times they felt that the situation in which they were violent towards their partner was a life or death scenario. Consequently, they used IPV directly in

response to their partner's violence or the violence they perceived was imminent. Participants gave examples which described grave danger in relation to the possible harm they were faced with. They spoke about seeing their reaction as necessary for their self-protection and even survival at that time due to the nature of possible harm they perceived from their partner. For three participants it seemed their perception was that their life was about to end and they instinctively defended themselves using extreme strategies.

P: There's nae way I could have got out that situation any other way. He [partner] came towards me with a hammer and the only thing I could grab right next to me was a wee knife. - Lisa

P: He [partner] had me in a headlock. He had me in a headlock and obviously the only way to get out of this headlock. I had to grab him by his [genetalia]...you know and I actually ripped his...that's how hard but I was like oh my god they only way I am gonna get out of this alive is if I get[tails off]...-Meg

Although these participants on these occasions appeared to report using violence as a direct response to the perceived threat on their lives, each of these participants also reported use of IPV on other occasions. It appeared from women's narratives that they were so accustomed to being in threatening or dangerous situations in their lives that they had learned to expect this across diverse settings and relationships, and within the specific relationship also.

Meg described witnessing her sister suffer severe violence from her partner where her sister suffered some serious injuries. Meg spoke about her sisters IPV related conviction towards her own partner, but suggested her sisters use of IPV was required because men are able to inflict more harm. Meg went on to describe a time where she inflicted more severe physical injuries on her partner during a fight which appeared to be related to her knowledge of her sisters experiences.

P: ...I say like seeing [sister's name] getting battered like that well I never letting a partner hit me...cause I seen it escalating from hitting, then it went to a kick in...went to like where [sisters name] was basically drugging [sister's partner] for [sister's partner] to fall asleep so she didn't get a bat...didn't get battered that night, so when I did see violence it was pretty severe.

I: ...And did it feel like that with you and [victims name]...that it escalated?

P: ...It was crazy man. See when I seen the state of [victims name] the next again day and that...I'm like what the fuck. – Meg.

The fact that Meg has experienced an incident where her life was at risk coupled with witnessing very severe violence that her sister was experiencing, appears to have led her to appraise scenarios which are not a life or death scenario as more dangerous than they infact are. Her sense of the situation appeared to be that her partner would inflict more harm on her. This overlaps with the theme of “the world is a dangerous place” in that participants already held appraisals about the world being a dangerous and hostile place which seems to have led to a heightened sense of threat in their relationships. This results in a difficulty differentiating between real and perceived danger and could perceive even minor altercations as a sign of threat. Their narratives typically conveyed that this was very real to them; they felt constantly hypervigilant to signs of threat. Consequently, participants described developing survival strategies just to feel they can survive in a world they perceive to be dangerous, and end up using violence in non-threatening situations because they believed there to be a real possibility of danger.

Theme 3: My life was out of control. This theme relates to participants conveying a sense of being at the mercy of all the bad things that happened in their lives. Participants gave accounts of a catalogue of traumatic events along with a sense of feeling that they had little control over whatever happened to them, including the

dangerous situations they found themselves in, their medical diagnoses, their mental health, their violent relationships, their emotions, and their substance misuse. It also encapsulated the idea that there was a lack of choice, lack of escape and often coincided with the feeling of being a victim. This theme was evidenced in all participants' narratives. Frequently participants appeared to give a very factual account of these experiences, almost reflecting a sense of expectation that all these things just happen to them, including the violence in their relationships. They gave a sense of feeling a lack of self-efficacy and of being stuck in their relationship.

Participants spoke about multiple traumas that they had experienced in their lives. One participant, for example spoke about feeling out of control and feeling the burden of all that had happened to her throughout her life on the night she committed her index offence of murder.

P: When I went oot that night I was 38...there was the sexual abuse and then getting into the relationship with my partner and the beatings, having to put my kids into care and losing my da...just carrying it aw. – Carol.

Participants also gave a sense of feeling out of control with the relationship and that they were in some way stuck.

P: The way [partner] was treating me...and just how stupid I was to kinda watch it unfold. I mean there was warning signs kinda...you know that things wernae right at times and how did you no get oot. You know I done a lot of self-blame you know...why did you no get oot in the first place and how did yi gee up yer hoose you know. I think I went through a lot of different emotions wi him. - Carol

The reference to being so emotionally out of control was pervasive in all of the transcripts, with women often attributing their violence to their inability to manage their negative emotions, for example when feeling angry, let down or betrayed by

others. It is also representative of the participants feeling a loss of control accompanied by the experience that they are themselves victims of violence.

One participant spoke of her emotions being all over the place, and self-medicating in order to manage this. Her narrative highlights that she was confused and did not really understand what she was feeling.

I: And if you are to think back...looking back on it all now. What sense have you made of your part in using violence...why do you think it happened on those occasions?

P: cause it' the only way I knew how to react with my emotion and the way I was feeling at the time. I didn't know that I had borderline personality disorder so I was self-medicating so if I wasn't drinking I would be smoking cannabis...- Jackie

Participants also conveyed a sense of their behaviour also being out of control in response to these traumas, their sense of being stuck in the relationship and their emotion dysregulation.

One participant talked of experiencing a “red mist” and being so caught up in her emotions, that she was unable to control her actions.

P: I just wanna kill him [partner]. There and then. It's like basically sometimes I get really really angry and then I just black out and stuff you know what I mean. It's just basically when I get really angry the anger just basically I just basically go violent you know what I mean and I just basically go for him and that's it so simple. – Kate

P: I cannae even remember doing it, it just sortae went black. I think if it didnae snap (weapon) I would have continued till I killed him [partner]. But I regret doing it cause I got sentenced to 200 hours community service- Lisa

This theme overlaps with the previous theme of “the world is a dangerous place” as it typically appeared that participants had developed a view that bad and dangerous things just happen to them and the resulting lack of a sense of agency in their world. These two things coupled together led them to their use of IPV.

Theme 4: People let you down. This theme encapsulated the idea that participants felt let down, not only by their partner evidenced in the subtheme “He’s not there for me” but also by services put there to support them, evidenced in the subtheme “Services are not there for me”. Participants spoke about times where they had used IPV to punish or get back at their partner for some wrong doing, for example being unfaithful to them. However, there was a sense from participants’ extracts that underlying their factual accounts of what happened, they may have felt let down, humiliated or uncared for. It appeared that when these beliefs came to the forefront of their mind, they were unable to manage their emotional reactions at the time. It is hypothesised that their emotional reaction were very powerful as they had repeated experiences of being let down or uncared for at a young age. Consequently, participants would use IPV impulsively as they were reminded of these experiences.

The subtheme “*He wasn’t there for me*” reflects participants sense of feeling let down in some way by their partner.

P: I couldn’t tell anybody at the funeral about my cousins death as the police were sniffing about. It was horrible. He wasn’t there. I just remember attacking him.- Jackie

This may have elicited cognitions around feeling uncared for or people letting you down.

P: I went away and got pissed cause it was my birthday with my aunties and that. They were the only ones who really cared eh. – Jackie.

For some participants, the painfulness of being let down by their partner seems to have been worsened by the fact they had invested so much in the relationship. Some participants' extracts gave a sense that there was disproportionate investment in the relationship from their side.

During Jackie's description of the relationship, she portrayed herself as someone who was always providing for her partner and that she supported him with his mental health difficulties, yet he was speaking to other women behind her back.

P: I was constantly keeping him going you know...money and making sure his house was alright and he didn't have to pay for anything with the kids as I would always make sure everything was there and in the end I was just...oh my god I have been so used. – Jackie

Jackie's extracts give a sense of being completely let down as she gave the impression that her 'partner wanted for nothing' but when she had this terrible experience of her cousin being murdered her partner was not there in the same way for her. It appeared that she was unable to manage her emotions at this time and used IPV as a way of regaining control in that moment. She did not appear to have any other means available to her to manage her emotional response.

Another participant spoke about how she felt escalation of physical violence on her part was justified due to her partner being unfaithful to her and that he deserved what he got.

P:...well I went I went mad and stuff like that and I just cheated him [partner] as well you know what I mean so (3 second pause) the gloves were off they were basically off and so that was it. – Kate

The phrase "the gloves were off" suggested that Kate saw violence as a means of getting back at him for what he had done.

Similarly, Kate may have felt she invested more in the relationship, particularly as she remained with her partner twice after he had been unfaithful and moved away from her family and friends to make a fresh start.

P: What happened from there? I basically started being on my guard and stuff like that and just basically we move away again from [name of town] and move back to [name of street] found out [victim] was still flipping fucking about again cause the thing is [victim] works away on the riggs and stuff like that so he travels a lot...-Kate

She goes on to talk about her perception of men in a more general sense.

P: Because they are fucking cheating dirty rats- Kate

Kate may have developed cognitions about men being untrustworthy which has led to her being hypervigilant - “started being on my guard and stuff”. The fact that he once again betrayed her confirmed her sense that men always let you down and should not be trusted. This extract highlights that Kate has developed a more generalised belief about men letting you down and being untrustworthy.

Another participant spoke about noticing a change in her partner after she gave birth to their daughter.

P: Oh it was horrible, I felt...I felt all by myself. I felt like I didn't have anybody. I felt like he [partner] didn't want to be with me but he was just here...for what I dunno. - Sheila

For these participants, there was a sense of being trapped and unable to leave the relationship or assert themselves in any other way. It seemed as though these women felt alone and uncared for, even when with their partner, but felt stuck in the relationship in some way.

For some participants, this sense of being let down seems to have been compounded by their experiences of being let down in childhood, particularly in relation to attachment experiences. Jackie cited common triggers to fights with her partner would be them arguing about her dad having walked out of her life in her childhood.

P: Yeah the anniversary of my dad's death and then the anniversary of my cousins death which would end up in big arguments and big fights. - Jackie

The fact that their partner had let them down may have served as a reminder to these earlier experiences and consequently, their emotional reaction was more extreme.

A further subtheme, '*Services are not there for me*', reflects participants' perceptions that they were also let down by support services. There was a sense that participants perceived the responses of support services at times to be invalidating, which may have further exacerbated their beliefs that "people let you down" and are not there to support you, and feelings of isolation and stuckness in existing relationships despite the volatility. One participant spoke of feeling almost like an unworthy member of society and that her word would not count for anything with, for example, the police because she was using drugs.

I: And what did you think about that?

P: And he's a police officer he should be more compassionate and understanding, do you know what I mean, cause the guy was making a habit of it, do you know what I mean, and he's just taken it as a one off...you are just a junkie just sitting in the house with nothing ken it's no gonnae go anywhere you will prob arrive up at court looking at me ken it's a waste of the courts time ken he's probably looked at it like that... - Moira

Another participant spoke about a physical fight between her and her partner where the police were called. This resulted in her first charge related to IPV, whilst her partner has had no charges.

P: Which I didnae think was very fair. Because obviously I had obviously like facial injuries. I had my teeth done in...you know shit like that. So how could they disprove that [partner] had done...like they couldnae. They could prove there was like physical evidence there that he had and there was like photos as well...- Meg.

Meg's extract highlights a sense of feeling invalidated by her experience of the police response which may have elicited beliefs of being uncared for, or nobody being there to listen to or help her. The fact that she was punished whilst her partner was not held accountable for what he had done, from her perspective may have exacerbated her sense of being trapped and helpless.

These underlying beliefs that participants seemed to hold about people letting them down, coupled with feeling that their partner was not going to be held accountable for their part in the violence, appeared to lead some women to feel they needed to take matters into their own hands.

One participant describes feeling like she had no other option to use IPV because of what her partner had done to her. She described stabbing him several weeks after she had woken up to find him on top of her sexually assaulting her. Following this, her more recent partner attacked her ex-partner because of what he had done to her. She then described how in order to ensure her partner wasn't convicted she was convinced to drop the charges against her ex-partner.

P: The police officer says 'well why don't we just not charge [ex partner's name], we'll go down and see him and have a word with him but then why don't you just leave it at that. It was the police officer that talked me outtae saying anything, do you know what I mean? - Moira

Overall, participants' narratives highlighted a sense of being stuck and trapped in the position they are in with nobody there to help them.

Theme 5: It's us as a couple. This theme reflected participants' beliefs that there was something about them and their partner together that was important in relation to the violence. Typically this seemed to reflect their sense that they had difficulties with managing their emotions, whilst their partner was aware of this and would deliberately 'push their buttons' and provoke them. Participants frequently suggested that their partner knew how to get to them, and knew how to get a reaction from them. This was evidenced in six of the participants' extracts.

P: ...So so shocked but even for me, I had never been violent with my partners and for me to be as violent as what I was with [partners name] I was like that...pfft

I: and that shocked you?

I: Aye no a good combination eh. – Meg.

Meg's narrative suggests that there was something particularly powerful about this relationship dynamic in that she had never been so violent before and was genuinely shocked about her behaviour.

Another participant described her partner using emotional abuse towards her but also indicated that she felt they both had a role to play in the violence.

P: When it came down to the violence am no saying it was all him [partner]...it takes two to tango...either way it always does. It doesnae matter who said what...it always takes two to tango but ken...he was older and wiser right...he took me under his wing ken I realise now that he took

me under his wing but he's older and wiser and he kent what buttons to push in me. – Diane

Diane's extract, where she states "he took me under his wing", suggests she may have had a belief about herself as "damaged" or "vulnerable" in some way, and almost suggested she saw her partner as a protector. She described him using some of her 'vulnerabilities' almost to his advantage, to 'push her buttons' and to get a reaction from her. She also spoke about how her partner would tell her nobody else would want her during arguments which may have compounded a sense of being stuck with him. This may reflect something these partners are doing to keep participants in the relationship and may reflect that he is also stuck. Her extract gives a sense that there is something powerful about the dynamic of the relationship that causes them to feel stuck in the relationship together.

Similarly, another participant refers to feeling that her partner would deliberately push her buttons and that this would typically involve focusing on her perceived vulnerabilities.

P: Aye [partner] would push my buttons. He would come back and say that nobody would want me and would make me think I would have to stay with him cause nobody would want me. Who's wanting somebody wae two bairns? He made me feel like I was in a box...like I could never get oot that box.- Lisa

Again this participants extracts gives the impression that there was something her partner was doing to keep her in the relationship "would make me think I would have to stay with him cause nobody would want me". She had previously spoke about her difficulties with feeling her emotions were all over the place due to previous violent relationships and also suffering from post-natal depression and suggested that her partner would use these things to get a rise from her as he knew this would hurt her.

Discussion

This research aimed to explore the underlying cognition within this sample for female perpetration of IPV. The findings from the study provide empirical support for the role of cognition in female perpetration of intimate partner violence and give preliminary support for understanding of how beliefs of female IPV perpetrators might influence their behaviour. This may be central to how IPV is both conceptualised and managed. Several themes were identified which can be understood in relation to beliefs these women hold about themselves, their relationships and the world, and which may have underpinned their motives for IPV. The participants appeared to have developed particular appraisals about themselves, others and their immediate social context which allowed them to interpret the world and impacted on their interpersonal relationships. This runs parallel to more recent work which has started to examine how offenders make sense of their social world and helps explain what motivates them to use IPV. These underlying cognitions are important to identify as without intervention, may perpetuate their offending. Some of the themes identified in the current study have similarities to what is described in the literature about how ITs help us to understand offending behaviour. This highlights that there may be some overlap in female IPV with cognitions of other specific offending groups.

“The world is a dangerous place” is similar to the theme “dangerous world” which was previously described by Dempsey and Day (2011) in relation to ITs in IPV male offenders, and in Weldon (2016) in male domestically violent sexual offenders. This theme relates specifically to the view that an individual must be protective of oneself from possible exploitation by others and that no-one should be trusted. It was evidenced in all participants in the current study and it could be hypothesised that these ITs developed at a young age due to adverse environmental, familial and attachment experiences. This has been hypothesised in other offending populations (Dempsey and Day, 2011; Weldon, 2016). Similarly, several of the women spoke about violence within their family home in childhood. This is consistent with previous research which has shown that male and female perpetrators have a history of witnessing inter-parental violence (e.g. Dowd *et al.*, 2005; Henning *et al.*, 2003;

Kernsmith, 2005). Participants in this current study spoke about experiences in childhood such as violence being used within their peer group and the family home, which appears to have contributed to their beliefs of the world as “*the world is a dangerous place*”. According to social learning and social cognitive theories (Bandura, 1973, 1977) and the theoretical model of intergenerational transmission of violence (Stith *et al.*, 2000), such experiences can inform one’s beliefs about the acceptability of violence between partners (Riggs & O’Leary, 1996; Stith *et al.*, 2000). Similarly, a systematic review by Pornari *et al.*, (2013) showed evidence of “normalisation of relationship violence” in both males and females, similar to the IT “violence is normal” identified in the study by Weldon (2016).

The theme “*My life is out of control*” bears similarity to the “uncontrollability” implicit theory found in sexual and violent offenders (Beech *et al.*, 2005; Poloschek *et al.*, 2009). A review of the literature pertaining to cognitive structures of IPV male offenders was conducted by Gilchrist (2009). This review proposed “uncontrollability” as an IT for males to capture their tendency to blame outside stressors, such as alcohol, for their IPV. Similarly, Pornari *et al.*, (2013) proposed a broader IT of “It’s not my fault” in order to capture women’s propensity to externalise accountability: they did not just blame factors out of their control but also factors associated with their victim. These two aforementioned themes may suggest core ITs that are common to offenders.

However, the theme of “*My life is out of control*” in the current study was somewhat different in that women did not generally blame external factors, but rather gave a sense of feeling completely at the mercy of what had happened in their life overall. Their narratives suggested that they felt confused about their experiences, their emotions and behaviour. The high prevalence of this theme may suggest that many female IPV offenders believe that their ability to control critical aspects of their lives is deeply compromised.

Findings from this study demonstrate some distinct differences to those specific ITs identified in other studies of male IPV perpetrators and other offending groups.

Women in the current study had also held beliefs such as “*It was him or me*”, highlighting that women had been faced with often repeated experiences of real danger and abuse in their lives which at times was also present in their relationships. There were times however, when women were responding to the perception, rather than the reality, of danger. Another novel theme “*People let you down*” highlighted women’s sense of being alone with their traumatic experiences, and also that they themselves were victims of violence, but perceived services were not there to support them or hold their partner accountable for what they had done. This contributed to women’s sense of helplessness and lack of self-efficacy. Similarly, as evidenced in this theme participants also described times where there appeared to be an imbalance of investment into the relationship as evidenced in the theme. This is fitting with one of the known characteristics people with borderline personality disorder may present with, in that they may make frantic attempts to avoid real or imagined abandonment, resulting on them focusing on the needs of others, even to their own detriment.

The final novel theme “*It’s us as a couple*” incorporated the high rates of emotion dysregulation in women who had experienced repeated dangerous and threatening scenarios in their life, resulting in pro-violence beliefs. Their narratives highlighted that their partners may have had similar difficulties, and that despite the volatility of the relationship, there was something that kept them together. This theme resonates with recent research that has begun to examine how each partner’s personality might influence the others behaviour (Maneta *et al.*, 2013). This study aimed to consider the attributes of both partners in the dyad to understand not only individual differences but also how these characteristics might influence partners’ behaviour. The study found that more BPD pathology in both men women was associated with increased victimisation. The authors proposed that it may be that those higher in BPD traits are more likely to couple with a partner who is more prone to violence. In addition, individuals with BPD traits may have deficits in self-regulation which make them more likely to use aggressive behaviour, and their violence may in turn elicit more aggressive reactions from their partner. Similarly, they suggest that difficulties with self-regulatory problems in one partner could lead to anger provocation in the other and then a lack of ability to help diffuse that anger (Maneta *et al.*, 2013).

Implications for practice

The identification of novel themes in the current sample compared to those identified in other offending groups highlight that there may be essential differences in women's pathways into IPV. These novel ITs identified do however, bare similarities to what is known about general female offending. It has been documented in the literature that female offenders suffer from high rates of complex trauma, emotion dysregulation, and lack self-efficacy, which impacts on their offending (Cornston, 2007). Consequently, findings of this study may support gender as an important focus in understanding factors relevant to offending behaviour and how it is treated.

This has implication for the development of appropriate treatment programs which are sensitive to the needs of the general female offender population. This fits theoretically well with calls for more gender-responsive programs addressing the needs of female offenders (Blanchette and Brown, 2006; Scottish Government, 2011). These calls have led to the development of trauma-informed services to meet the needs of female offenders (Cornston, 2007)

Intervention

Given that women who perpetrate IPV appear to have beliefs that could underpin their offending, it is important that these are considered in intervention or management programmes. It may be that without intervention, these underlying beliefs may perpetuate their offending. It would be the role of the clinician to /support bringing these beliefs to the forefront and to incorporate these cognitions into a psychological formulation. This would support the women to make links between these beliefs and their use of IPV. This may help women feel less confused about their experiences, their emotions and their behaviour, evidenced in the theme "*My life is out of control*". It would be the role of the clinician to help normalise this confused feeling based on the women's experiences.

Within intervention these problematic ITs could then be incorporated into pre-treatment assessment and the intervention itself within trauma-informed services. The ITs themselves can be translated into dynamic risk factors and treatment targets (Dempsey & Day, 2011; Weldon 2016). Therefore, the themes evidenced in this study which are similar to previously identified ITs could be incorporated into a psychological formulation and then be translated into treatment targets. It would be the role of the clinician to help support female IPV perpetrators to re-evaluate information linked with their offending and to develop more adaptive ways of thinking about themselves, others and their lives.

However, the findings from the current study suggest that this work cannot be done in isolation and there are other important factors to consider in intervention with this population. It was evident from participants' narratives that the context of these women's lives would need to be given consideration for any meaningful change to occur. These women may still be in relationships which are violent or in situations which perpetuate their view of the world as a dangerous place whilst at the same time lacking in self-efficacy and feeling that there is nobody to protect or help them. In intervention it may be helpful to consider coupling a formulation driven and trauma informed focus with a contextual focus. The Structured Clinical Care approach may fit well with this (Bateman & Fonagy, 2009). This is a generalist approach in working with patients with personality disorder. It involves an entire clinical team working underpinned with a joint formulation of the patient in an environment that is responsive to the patients' needs. It aims to provide a more consistent, boundaried and empathic approach which is systematically applied, aiming to help those with PD have a different experience of their environment and thus, learn to interact with their environment in a different way. It also aims to help the individual develop a better understanding of their own internal states of mind and learn and practice skills to manage emotions/impulses/relationships more effectively (Bateman and Fonagy, 2009). This may be helpful in allowing the women to feel supported by services and enhance their sense of self efficacy.

Intervention should also consider the dynamic of the relationship as evidenced in the novel theme “*It’s us as a couple*”. This may allow for clinicians to identify the underlying psychological mechanisms for the use of IPV within the couple, which could then be targeted in intervention.

Risk assessment and management

The theme “It was him or me” also has implications for risk assessment and management given that women who fight back are more likely to get injured (Swan et al., 2008). This may require longer term intervention targeting the sequelae of complex trauma including addressing women’s hypervigilance. This requires trauma-informed services that ask about and assess these issues.

In relation to management of this population, the subtheme “Services are not there for me”, has implications for the responses of services. It is important that women feel believed and supported. It may be helpful to consider training of frontline professionals supporting those with IPV in understanding the context of this phenomenon, and how responses may impact and maintain cognitions of these offenders. This is consistent with a study by Simiao *et al.*, (2015) which aimed to explore women’s experiences of arrest experiences. The findings of the study highlighted that women felt arrest decisions by police were based on limited understanding of context.

Limitations of the current study

The sample size within the current study was small and self-selected (each participant elected to be interviewed), challenging generalisability. The present findings, however provide useful information that broaden our understanding of what may be underlying women’s motivations for IPV from their own perspective. The sample was also derived from two different recruitment sites (prison and community) which may affect the homogeneity of the sample. It may be that those who are in prison settings are more generally violent than those in the community and the fundamental differences in where participants are in their journey within the criminal justice system may have impact in their ability be insightful about their experiences.

However, it was thought to be important to capture the range of female perpetration of IPV- from minor to more serious IPV. Furthermore, there was marked consistency in the participants' narratives across the two settings evidenced by the themes occurring across participants.

Future research

Through conducting this research it was evident that there were more women who self-reported IPV which had not resulted in a charge or conviction. In order to make broader generalisations to all criminal justice involved women, it would be useful to explore self-reported IPV which did not result in a charge or conviction or women not involved in the criminal justice system. The proposed ITs identified could be extrapolated into a questionnaire to be distributed to a wider audience for empirical validation. It would also be useful to explore cognition in females who had used IPV in a same sex relationship for comparison and to identify potential further treatment targets.

It is hoped that through dissemination, these findings add to the extant knowledge of female perpetration of IPV, and may inform the need to refocus research efforts into exploring distinct cognition in this population and the need for clinical intervention using trauma informed services.

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APPENDICES

Appendix 1

Manuscript Guidelines for International Journal of Forensic Mental Health

There is no word count for the International Journal of Forensic Mental Health

References. References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 6th ed. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article. *Examples: Journal:* Tsai, M., & Wagner, N.N. (1978). Therapy groups for women sexually molested as children. *Archives of Sexual Behaviour*, 7(6), 417-427. doi: 10.1037/0096-3445.134.2.258

Book: Millman, M. (1980). *Such a pretty face*. New York: W.W. Norton.

Contribution to a Book: Hartley, J.T., & Walsh, D.A. (1980). Contemporary issues in adult development of learning. In I.W. Poon (ed.). *Ageing jin the 1980s* (pp. 239-252). Washington, DC: American Psychological Association.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

Color Illustrations. Color art will be reproduced in color in the online publication at no additional cost to the author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Color reprints can only be ordered if print reproduction costs are paid. Print Reproduction: \$900 for the first page of color; \$450 per page for the

next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

Tables and Figures. Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

Appendix 2.

Quality Rating Criteria

1. STUDY DESIGN

1.1	Is the study addressing a clear and focused question and are the aims and/or hypotheses clearly stated?	0= Poor 1= Fair 2=Good	
1.2	Is the design appropriate for addressing the study question?	0= Poor 1= Fair 2= Good	

2. METHODS

2.1	Is the population being studied clearly described and is the sample representative of the population? (e. g. what is the selection criteria?)	0= Poor 1= Fair 2= Good	
2.2	How was the sample selected? (Is the eligibility criteria and the sources and methods of selection of participants adequately described)	0= Poor 1= Fair 2= Good	
2.3	Is the sample size justified? (e.g. if a mixed gender sample, is the female sample large enough to adequately address gender-specific questions?)	0= Poor 1= Fair 2= Good	

2.4	What was the response rate? (%)	0= Poor 1= Fair 2= Good	
2.5	Are the participants adequately described (e.g. relevant demographics).	0= Poor 1= Fair 2= Good	

3. MEASUREMENT

3.1	Is the study clear as to the type(s) of abuse measured within the study?*	0= Poor 1= Fair 2= Good	
	1=an explicit statement of whether the types of abuse include physical, sexual, and/or emotional abuse (i.e., does not just say “abusive” or “violent” to define a relationship). 2= Use of validated measure		
3.2	Are the measures used reliable and valid for use with the study population (e.g. are they valid for use with women?)	0= Poor 1= Fair 2= Good	
3.3	Is the timing of the data collection specified? (this specification of dates is important in that it allows for interpretation of the results in light of any significant historical events that may have occurred during the period of data collection)	0= Poor 1= Fair 2= Good	

3.4	What was the drop-out rate? (%)	0= Poor 1= Fair 2= Good	
3.5	Is a control for social desirability used?	0= Poor 1= Fair 2= Good	
3.6	Personality correlates are clearly described 1= clear statement of potential PD diagnostic criteria 2= use of measure to assess PD	0= Poor 1= Fair 2= Good	
2.5	Are main potential confounding variables taken into account? (e.g. gender-specific criminogenic needs)	0= Poor 1= Fair 2= Good	

4. DATA

4.1	Is the use of statistical analyses appropriate? (e.g. are confounding variables controlled for?)	0= Poor 1= Fair 2= Good	
4.2	Is the study large enough? (e.g. sample size justification and statistical power)	0= Poor 1= Fair 2= Good	
4.3	Are the data adequately described? (incl. tables and summary statistics describing the sample and adequate information on the results of	0= Poor 1= Fair 2= Good	

	analyses).		
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5. INTERPRETATION

5.1	Is there evidence of any other bias? (e.g. funding bias)	0= Poor 1= Fair 2= Good	
5.2	Are important factors overlooked? (e.g. other factors that may have influenced personality traits over time)	0= Poor 1= Fair 2= Good	
5.3	Can the results be generalised?	0= Poor 1= Fair 2= Good	

TOTAL QUALITY SCORE (max possible = 42)	
--	--

Rating scale:

0 = not reported, not addressed, poorly addressed

1 = adequately addressed

2 = well addressed

Appendix 3.

Manuscript Guidelines for Journal of Family Violence

The entire manuscript should adhere to APA 6th edition standards including: Times New Roman 12 pt. font, 1" all around page margins, with a page header at ½" and entire manuscript should be double spaced, left aligned with .5" first line indents. Quotations, references, figure-caption list, and tables must also adhere to APA 6th edition guidelines. With quotations of 40 or more words, DO NOT use quotation marks. Set off the quotation in Block style format indented ½". Number all pages consecutively with Arabic numerals, with the title page being page 1 and include a running head on all pages. The suggested running head should be less than 40 characters (including spaces) and should comprise the article title or an abbreviated version thereof

A title page should be uploaded as the first page of the manuscript and should include only the title of the article. Do not include author's name or author's affiliation or other identifying names since the manuscripts undergo anonymous reviews. An abstract is to be provided, and should be no more than 150 words. Abstract should be flush left and left-aligned. A list of 4–8 key words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. Where there are six or more authors, only the first author's name is given in the text, followed by et al., unless there are more than two references with the same author surname and same year. In this case, list as many others as needed (usually no more than two or three) to indicate which reference you are referring to followed by et al. Journal Article - Elements Needed: Author's surname and initials of first and middle name (if given). (Year of publication). Title of article. Publication information which includes: Journal title and volume number (italicized), the inclusive page numbers, and the digital object identifier (DOI) if one is assigned.

Periodicals with Three to Seven Authors

Georgesen, J. C., Harris, M. J., Milich, R., & Young, J. (1999). "Just teasing...": Personality effects on perceptions and life narratives of childhood teasing. *Personality and Social Psychology Bulletin*, 25(10), 1254-1267.

- Periodical with More than Seven Authors (cite first six authors, three ellipsis points, and final author. If seven authors, list all seven).

Kaukiainen, A., Bjorkqvist, K., Lagerspetz, K., Osterman, K., Salmivalli, D., Rothberg, S., ... Jones, K. (1999). The relationships between social intelligence, empathy, and three types of aggression. *Aggressive Behavior*, 25(2), 81-89.

Book - Elements needed: Book authors or editors, date of publication, book title, city and state in which publisher is located, and name of publishing company.

Elkind, D. (1978). *The child's reality: Three developmental themes*. Hoboken, NJ: Lawrence Erlbaum Associates.

Contribution to a Book – Elements needed: Author's surname and initials of first and middle name (if given), date of publication. Title of article or chapter. "In" book author or editors "(Eds.)", book title ("pp." page numbers), city and state in which publisher is located, and name of publishing company.

Duckworth, J. C., & Levitt, E. E. (1994). Minnesota Multiphasic Personality Inventory-2. In D. J. Keyser & R. C. Sweetland (Eds.), *Test critiques: Vol. 10* (pp. 424- 428). Austin, TX: Pro-Ed.

Footnotes

Footnotes should be avoided. When their use is absolutely necessary, footnotes should be numbered consecutively using Arabic numerals and should be typed at the bottom of the page to which they refer. Place a line above the footnote, so that it is set off from the text. Use the appropriate superscript numeral for citation in the text.

APA Tips

Acronyms

Acronyms should always be spelled out the first time used. For example, Minnesota Multiphasic Personality Inventory (MMPI); posttraumatic stress disorder (PTSD); Diagnostic and Statistical Manual of Mental Disorders (DSM). Thereafter, use the acronym.

Appendix 4.

Semi-structured interview schedule

General opener/identify relationship and establish type of abuse/violence

1. How it began

Can you tell me how the (identified abuse) began?

Prompts:

- Was the relationship always like that or did it change over time?
- Were there any triggers?

2. Frequency/severity

How bad did it get?

Prompts:

- What was the worst time?
- Were there injuries/hospital treatment?
- Were the police called more than once?

3. Reflection/motivation

Looking back, what sense do you make of what happened?

Prompts:

- Why do you think it happened?
- Were there triggers/specific times it was more likely to happen?

4. Violence within other partner relationships

Have there been other partners where similar things have happened?

- Can you tell me a bit about these?
- Did this feel the same or different from with the partner we've just been discussing?

5. Similar behaviours/violence outwith intimate relationships

Have there been any other times where (similar things have happened) in non-intimate relationship (e.g. family friends, strangers)?

Prompts:

- Have you had other charges for (similar abusive behaviour) towards others e.g. family, friends, strangers
 - Can you tell me a bit about these?
 - Did these feel the same or different from with your partner(s)?
 - Why do you think this happened? (triggers)
5. Any other thoughts

Is there any other information about what we've been discussing in your relationships which we haven't talked about today which you think would be important for me to know?

Appendix 5.

NHS Ethical approval

14-SS-1047 SA03 July 2015 Fav Opinion.pdf - Google Chrome
https://web.nhs.net/OWA/WebReadyView.aspx?t=att&id=RgAAAAB45yIUvkhRY9minbqAm%2bx8wCgWxYQVdINQYloA%2bR6xj5AAA4NKLFACgWxYQVdINQYloA%2bR6xj5AABML15IAAA

You are currently viewing: 14-SS-1047 SA03 July 2015...pdf (73 KB) Help

For security reasons, this attachment may only be viewed as a Web page. It cannot be saved to disk.

Page 1 of 3

Lothian NHS Board

Mrs Lauren Forrest
Psychology Department
Royal Edinburgh Hospital
Mackinnon House
Morningside Terrace, Edinburgh
EH10 5HF

South East Scotland Research
Ethics Committee 01

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 636 9000
www.nhslothian.scot.nhs.uk

Date: 28 July 2015
Your Ref
Our Ref

Enquiries to: Sandra Wylie
Extension: 35473
Direct Line: 0131 465 5473
Email: Sandra.Wylie@nhslothian.scot.nhs.uk

NHS
Lothian

Dear Mrs Forrest

Study title: Motivations and cognitions in females charged or convicted of intimate partner violence
REC reference: 14/SS/1047
Amendment number: 03
Amendment date: 27 July 2015
IRAS project ID: 157818

The above amendment was reviewed by the Sub-Committee in correspondence.

13:03 25/01/2016

14-SS-1047 SA03 July 2015 Fav Opinion.pdf - Google Chrome

<https://web.nhs.net/OWA/WebReadyView.aspx?t=att&id=RgAAAAAB45yIUUVkhRY9minbqAm%2bxBwCgWxYQVdINQYloA%2bR6xj5AAAA4NKLFACgWxYQVdINQYloA%2bR6xj5AABML1SIAAA>

You are currently viewing: 14-SS-1047 SA03 July 2015...pdf (73 KB)

For security reasons, this attachment may only be viewed as a Web page. It cannot be saved to disk.

Page 1 of 3

IRAS project ID: 157818

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Committee had no ethical concerns regarding this amendment and were satisfied with the improved Patient Information Sheet and revised Consent Form.


Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMP)		27 July 2015
Participant consent form	2	17 July 2015
Participant information sheet (PIS)	2	17 July 2015

Membership of the Committee

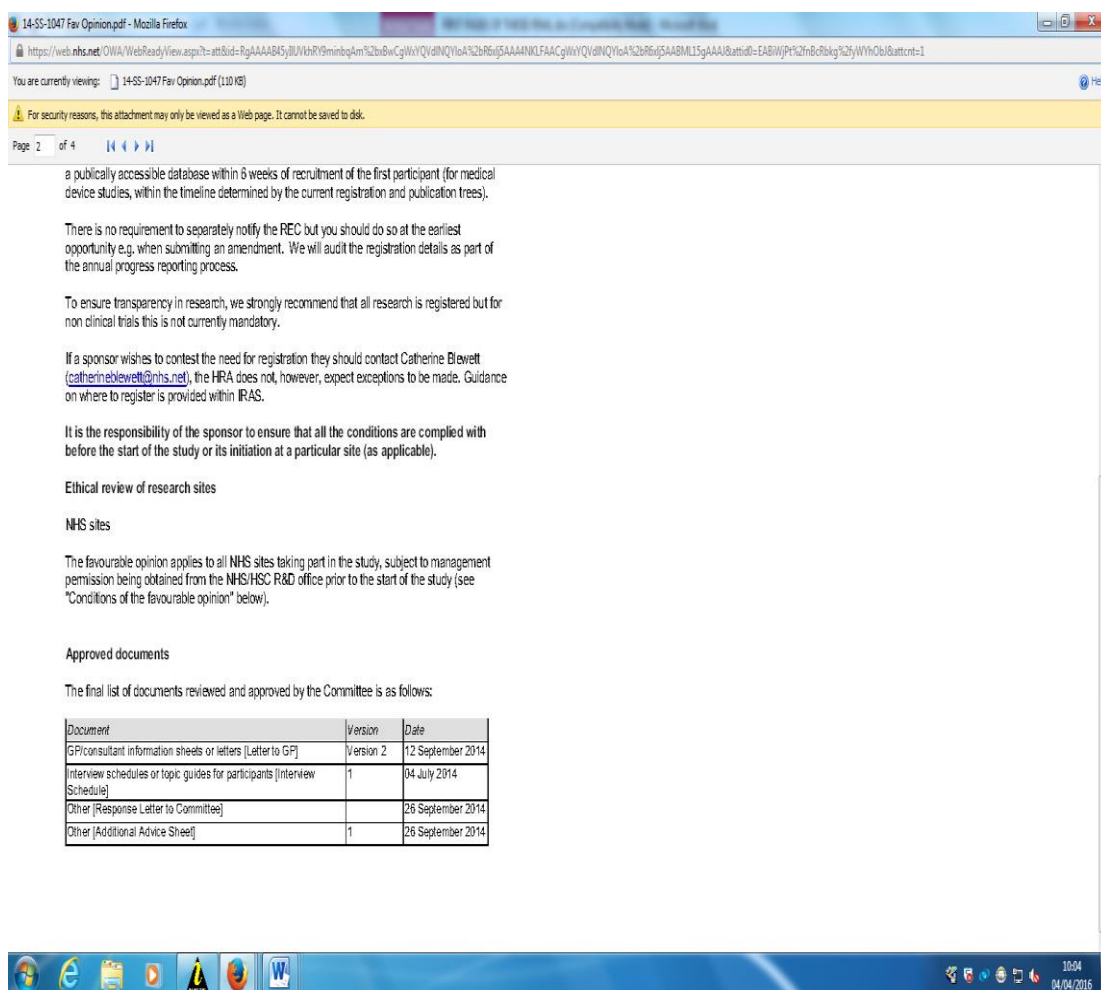
The members of the Committee who took part in the review are listed on the attached sheet.



Headquarters
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair Mr Brian Houston
Chief Executive Tim Davison
Lothian NHS Board is the common name of Lothian Health Board

Taskbar: 13:08 25/01/2016



Appendix 6.

City of Edinburgh Council ethical approval

DEPARTMENT OF HEALTH AND SOCIAL CARE
SOCIAL CARE PERFORMANCE

Lauren Forrest
School of Health in Social Science
Old Medical School
Teviot Place
Edinburgh EH1 2QZ

Date: 20th August 2014

Your ref:

Our ref:

Dear Lauren,

MOTIVATIONS AND COGNITIONS IN FEMALES CHARGED OR CONVICTED OF INTIMATE PARTNER VIOLENCE

Thank you for the documents in support of your request for research access, and for the clarification of data collection issues following our meeting in July.

I understand also that your proposal in relation to women charged with, or convicted of intimate partner violence has been discussed with Kirsty Pate and other Willow Centre staff and that they are happy to support you in this study. I am pleased then to confirm that your request for access to Willow Centre service users and staff members has been approved.

Please contact me if you need further assistance.

I hope that your project goes well, and I look forward to receiving a summary report on your findings

Yours sincerely

Mary Rhodes
Senior Research and Information Officer
Telephone No.0131-553-8393
Waverley Court Business Centre No.1/7

Cc Kirsty Pate, Manager, Willow Centre.

PETER GABBITAS
DIRECTOR

Waverley Court, Business Centre 1-8, 4 East Market Street, Edinburgh, EH8 8BG
Tel 0131 553 8319 Fax 0131 529 6218



Appendix 7.

Scottish Prison Service ethical approval

NHSmail

Calendar

Contacts

Deleted Items

Drafts [134]

Inbox

Junk E-Mail

Sent Items

Click to view all folders

Ethics

Manage Folders...

RE: Research Ethics Application [SEC=OFFICIAL]

Carnie James [James.Carnie@sps.pnn.gov.uk]

You forwarded this message on 01/09/2015 12:24.

Sent: 12 August 2015 17:15

To: Forrest Lauren (NHS LOTHIAN)

Cc: Davidson Paul [Paul.Davidson@sps.pnn.gov.uk]; Davis Alana (NHS LOTHIAN); Clark Bryan [Bryan.Clark2@sps.pnn.gov.uk]

Attachments: RAEC - Access Regulations ~1.doc (26 KB) [Open as Web Page]

Lauren

The Research Access and Ethics Committee met this morning and was reassured by your research project outline and content to approve access.

Please sign the attached standard access regulations and return to me in Calton House.

Paul and I will stand ready to assist with the initial approaches to those women presenting with a domestic abuse flag. Let me know your timescales. Bryan can pull down an up to date list and I can target each establishment sequentially until the sample quota is reached. I suggest we start in Edinburgh first.

Thanks

Jim

From: Forrest Lauren (NHS LOTHIAN) [mailto:laurenforrest@nhs.net]

Sent: 23 July 2015 09:09

To: Carnie James

Subject: Research Ethics Application

Hi Jim

Thanks again for arranging to meet with Alana Davis and I to discuss my proposed research within SPS. It was also extremely helpful to have the input of Paul Davison. I now attach my completed SPS ethics form and associated documents for consideration at your August meeting.

Appendix 8.

Participant Information Sheet



PARTICIPANT INFORMATION SHEET

INVITATION TO PARTICIPATE IN RESEARCH STUDY

MOTIVATIONS AND COGNITION IN FEMALE

INTIMATE PARTNER VIOLENCE INFORMATION SHEET

Dear Participant

My name is Lauren Forrest and I am studying for my PhD at University of Edinburgh. As part of this I am carrying out some research and invite you to take part in the following study. However, before you decide to do so, I need to be sure that firstly, you understand why I am doing it and secondly, what it would involve if you agreed. I am therefore providing you with the following information. Please read it carefully and be sure to ask any questions you might have, and if you want, discuss it with others including your friends and family. I will do my best to explain the project to you and with any further information you may ask for now or later.

The Willow Service, NHS Lothian and Edinburgh City Council- criminal justice authority is supporting this research project. The services hope this will help them to find out more about violence in relationships and how they assess and provide treatment for this.

What is the purpose of this study?

Lauren will explore individual motivations (reasons for) and circumstances involving violence in your relationships. Intimate partner violence (IPV) might involve using physical violence against an intimate partner, for example, hitting, kicking, pushing.

It might involve trying to make someone feel bad about themselves or using threats of harming someone. It could also involve controlling behaviour, for example telling them that they can't do something or checking their phone/e-mail/facebook a lot of the time, in a way that became a problem in your relationship. Another form of violence could be trying to get a partner to do something sexual that they might not want to do.

They will also explore your thoughts and feelings about your previous life experiences and violence in relationships. Lauren is very interested in finding out more about your experience and your views about what happened in your relationship to help understand more about these issues so that we can help support these issues better.

Why have I been asked to take part?

The study is looking to interview 8-12 females currently involved with the Willow or wider criminal justice authority in Edinburgh who has been convicted or has a charge linked to involvement in violence towards a partner.

What does taking part involve?

Lauren would like to ask you to take part in an interview which would take no more than 60-90 minutes of our time. The interview would be audio recorded and then transcribed (written up) by Lauren. Lauren will then delete the recording once it has been transcribed. Your name and any other names used would be changed to protect anonymity. Lauren will have been told about any charges or convictions you have relevant to the study. However, she will not have access to your full criminal records so there may be other past convictions that are not relevant to this study that the Lauren will not know about. Lauren will ask you as part of the interview more about any other charges or convictions you might have that are related to this topic.

The interview will take place either before or after one of your keyworking sessions, in the same location where you see your keyworker. Lauren would be happy to meet with you and your keyworker together before arranging an interview to tell you more about the research and answer any questions or concerns you might have.

In the interview you will be asked to describe your relationship with your current/previous intimate partner. You will be asked to talk about the violence in your relationship and your part in it and also your thoughts and feelings about this. Before the interview starts, Lauren will also ask you for some basic background information (e.g. your age, if you are married or not, and how many times you have been in contact with the criminal justice system).

Confidentiality

All of the information you give to Lauren will be anonymous and confidential. That means that the information will not be reported back to your keyworker or doctor. However, if there are disclosures relating to potential self-harm or to the potential harm of others or to undisclosed criminal activity (for example disclosing that you are still seeing a previous intimate partner which may be a breach of any orders you have) she will have to pass that information on to the appropriate authorities (your keyworker).

The information you give in the study will be stored in a secure and anonymous way. That means that if you take part in the study, you will be given a unique research number. Only this number will be shown in the information stored about you. The recorded interview will be kept in a locked filing cabinet. After the interview has been transcribed (written up) by Lauren, the recording will be deleted. All information you provide will be kept in locked filing cabinets and on password protected computer. Only Lauren and members of the research team will be able to access this information.

Your participation is entirely voluntary and you are under no obligation to answer any questions you do not feel comfortable with. You are free to withdraw from the study at any time you choose. Your involvement in this study will no way impact on your involvement with the criminal justice system. The research data gathered will be destroyed after the study has been concluded.

What are the possible benefits of taking part?

Lauren hopes that by listening and showing interest in your experiences will be of benefit to you, and hopefully you will find it interesting taking part. Exploring these issues will help services understand the problem better which will help them think about appropriate assessment and treatment.

Taking part or not will have no effect on your charges or convictions (positively or negatively) or your access to treatment in Willow or criminal justice.

What will happen to the results of the study?

The results will be available within a year after the study is finished. Reports of the study will be based on interviews with all the women who took part. The reports will describe the experiences of the group of women as a whole and will not identify any women. The reports will change the name of all women involved in the study. The

results will be presented to local services and to researchers nationally. If you would like to, you will receive a copy of the research findings.

Who is organising and funding the research?

The study is organised by the Doctoral Clinical Psychology Programme at University of Edinburgh. It is supervised by Dr Ethel Quayle, Senior Lecture, Dr. Alana Davis, Clinical Psychologist and Dr Suzie Black, Clinical Psychologist. The research is funded by NHS Education for Scotland.

Where can I get more information or sign up for the study?

Please tell your keyworker that you are interested in hearing more about the study or in taking part. He/she will contact Lauren Forrest who will then contact you.

Should you wish to speak to someone who is not directly involved in the study for independent advice you can contact the **Independent Advisor, Emily Newman, Research Director, Room 2.1, Health and Social Sciences, University of Edinburgh**, e-mail: Emily.newman@ed.ac.uk, telephone number: 0131 651 3945.

Thank you for taking the time to read and consider this request. If you would like to take part, please refer to the consent form attached.

Lauren Forrest, BSc (Hons) Psychology, MSc Psychological Therapy in Primary Care

Clinical Psychology Doctorate Student, University of Edinburgh

Appendix 9.

Participant Consent Form



PARTICIPANT CONSENT FORM

Project Title: Motivations and cognition in females charged or convicted of intimate partner violence

Name of Researcher: Lauren Forrest

Trainee Clinical Psychologist

Willow Service, 3rd Floor, Laurison Buildings, Lauriston Place, Edinburgh

Contact Number: 07891794457 email: laurenforrest@nhs.net

Thank you for reading the information about our research project. If you would like to take part, please read and sign this form.

Participant's name: _____ Date of Birth _____
Service _____

- | | Please Tick |
|---|--------------------------|
| 1. I have read and understand the information sheet dated 06.2.15 (version 2) and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. This means that withdrawing will not affect my involvement in the criminal justice system or my access to psychological therapy. | <input type="checkbox"/> |
| 3. If I get upset during the interview, I can ask for the interview to be stopped. I can also ask to talk to the researcher at a later date if I would like to discuss anything I talked about during the interview. | <input type="checkbox"/> |

4. All the information I provide in the study will be anonymous and confidential. However, if I reveal information about an unreported crime or a crime about to be committed, or about future harm to myself or others, that information will have to be reported to the appropriate authorities. ☐
5. I give permission for my GP to be informed of my participation and given any relevant information. ☐
6. I agree to my interview being audio-recorded and transcribed. ☐
7. I agree to take part in the above study. ☐

Name of Participant

Signature

Date

Name of person taking consent

Signature

Date

Appendix. 10

Data Coding Sheet

	Variable Name	Variable Description
	Research ID	Participant Research ID Number
1.	Age	
2.	Ethnicity	0=white 1=black 2=asian 3=mixed origin 4=other
3.	Index Offence	Index Offence Category 0=Intimate Partner Violence 1=General violence (assault, culpable homicide, murder etc) 2=sexual 3=Acquisitive (robbery, theft, housebreaking, shop lifting) 4=drug 5=fraud 6=arson 7=violence & other (s) 8 sexual & other (s) 9=other
4.	Sentence/restrictions	

5.	Preconvictions	Number of preconvictions (excluding index offence)
6.	Current Relationship	Current relationship status at time of data collection 0=single (including divorced, separated, widowed) 1=in a relationship
7.	Children	Number of children
8.	Gender of Children	
9.	Alcohol Misuse	History of alcohol misuse Misuse=usage is addictive, problematic for the individual, has negative impact on functioning (e.g. relationships, employment, finances, link with offending)
10.	Drug Misuse	History of drug misuse Misuse=usage is addictive, problematic for the individual, has negative impact on functioning (e.g. relationships, employment, finances, link with offending)
11.	Childhood Victim	Woman has experienced childhood victimisation (witness or victim of psychological, emotional, physical or sexual abuse or neglect)
12.	Childhood Witness of IPV	Woman has witnessed domestic violence during her childhood.
13.	Personality Disorder	Woman has formal diagnosis of personality disorder

Appendix 11.

Reflective Journal

It is good practice for qualitative researchers to reflect on his or her experiences and assumptions related to the research (Law *et al.*, 1998). Consequently, throughout the research process, I deemed it important to keep a reflective journal. My experiences and assumptions related to the current study are outlined below.

I am a female trainee clinical psychologist in my last year of training. Prior to training as a clinical psychologist I worked as an Assistant Psychologist in a forensic service, working solely with men who have offended. During this post I developed an awareness of the adversities and trauma faced by many of those who have offended. I began to develop an interest in finding out more about the experience of female offenders, and the similarities and differences to their male counterparts.

Being a novel qualitative researcher

I found the process of qualitative research to be a learning curve as this was not a research method I had experience of using before. I was very aware throughout that I continuously doubted the decisions I was making. I feel that my inexperience may have interfered with my initial interviewing style and meant that I required supervision to encourage me to become more client led in my interviews and interpretative in my analysis. However, I believe having this awareness of inexperience and doubt was also helpful as it prompted me to be more aware of my decision making process and my influence over the analysis this therefore enhanced the quality of my research.

Talking to people who have offended

At times I found myself surprised at the severity of violence participants were telling me about. This made me aware of prior assumptions about violence by women perhaps not having the same severity or consequences as that perpetrated by men. It was therefore an invaluable experience to maintain a reflective journal to enhance self-awareness and reflect on prior assumptions.

Dual role of researcher and trainee clinical psychologist

Throughout the interview process I became extremely aware that my role of trainee clinical psychologist had a significant impact on my interview style. I felt my clinical psychology training meant that I was used to quickly developing rapport during interviews, conducting risk assessments and containing emotional distress. However, my familiarity with clinical interviews also meant that I struggled to stop being in the psychologist role. I found this particularly difficult as I was also working clinically with female offenders and therefore was “used to” offering help for their issues.

Extract 103: Reflective journal, 06/06/15

I found it very difficult not to jump into the “psychologist” role and start offering advice. Participants seem to provide a very factual and behavioural account of their experiences. It’s difficult not to summarise, reflect back and attach a meaning, and encourage the women to make links. It’s hard not leading but being completely neutral and just curious. . I also found it difficult not to offer help when a participant was obviously struggling with difficult emotions.

Emotional Impact

Throughout the interviews participants described distressing experiences and expressed powerful (generally negative) emotions. This, inevitably, had an impact on me. I often found that participant narratives made me feel tremendously sad and often powerless. Although, I discussed possible sources of support with participants following the interview, I generally felt that I would have liked to have offered them

more help. At times I think I found it difficult tolerating negative emotions because I knew that I would not be offering them the opportunity to work through these which is contrary to my role as Trainee Clinical Psychologist. In addition, I think the process of transcribing interviews and having to listen to accounts of distress over and over while at home, made the research often much more emotionally demanding than my clinical work.

In addition to negative emotions I often felt a sense of admiration at the way participants had coped with such difficult experiences. Overall, participants' narratives showed them to be inspiring and resilient individuals who had survived some horrific experiences. However, in general participants did not seem to share my view of themselves and spoke about how they did not think they had coped well.

Reactions of participants

During the process I was impressed by participants' willingness to share their stories and difficult experiences. There was a real sense of openness.

Extract 104: Reflective journal, 19/08/15

I feel privileged people are telling me information they have never told anyone else before particularly in an area that people may feel a great sense of shame. I understand why people would share such information in therapy sessions: its longer term and the person would have expectations that it might help. But telling a researcher who they will never see again? Is that easier? Maybe they feel it is very important to say the truth to a researcher? Maybe nobody has asked them before; nobody has taken an interest or has given them the opportunity as they assumed they would not be willing to talk about it?

I was surprised that people were prepared to discuss such distressing experiences so openly. An unexpected outcome of the process was that most of the participants reported that they had received some therapeutic benefit (perhaps an opportunity to try make sense of their experiences) from the interview. Several of the women also

indicated that they did not mind talking about it as they hoped it would help other women with similar experiences. I feel inspired that despite their suffering they are thinking about others. It is important to note that throughout the experience there were some women who initially said they would be willing to participate but later declined as they thought it may evoke painful memories and emotions for them.

Data analysis

I approached the analysis with the assumption that the experience of perpetrating intimate partner violence has psychological implications. As a trainee clinical Psychologist, I felt I brought to the analysis my knowledge of psychological theory and concepts, mental health problems and some knowledge of current research on domestic violence. Throughout the research process, I tried to be mindful of my prior knowledge and assumptions and endeavoured to ensure that themes emerged from participant narratives. However, as I was explicitly attempting to explore the psychological processes involved in the participants lived experiences of IPV, my prior assumptions undoubtedly shaped the analysis. Furthermore, I believe that some of the terminology I used within the analysis might not have been introduced by someone who did not have a background in psychology. However, despite these issues, every care was taken to ensure that themes were grounded in the data and it did appear that perpetration of IPV had profound psychological implications.

Impact of research on clinical work

I found the experience of conducting a qualitative study had a positive impact on my clinical work particularly as I am working clinically with female offenders. Listening to, transcribing and reflecting upon interviews encouraged me to reflect on my interview style. For example, I realised that I often asked a question and then gave participants some possible answers. Obviously, this limited participant's responses and was therefore not an ideal interview style. Becoming aware of this habit and trying not to do it, allowed me to be more client led in my clinical interviews.

Similarly, as I adjusted to not falling into the helper role I was able to appreciate the value of simply providing a safe space can have a curative element as many of the women were able to say that they found just talking about it helpful. Participants often said that they had not been asked about their own involvement in IPV so it has helped me be more mindful about what we just don't ask in clinical practice which may cause us to miss an important piece of our formulation. I have also found the research experience invaluable in understanding the other roles of clinical psychology, for example the role of influencing public policy.